

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10042

10045

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL		d. STREET ADDRESS 525 PINE AVENUE	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First HARRY Middle E. Last ADAMS		4. DATE OF DEATH Month OCTOBER Day 5 Year 19 57.	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JANUARY 8, 1900
9. AGE (In years last birthday) yrs. 57		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Hout Constr. Co	
11. BIRTHPLACE (State or foreign country) PENNSYLVANIA, Chaneyville		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME JACOB ADAMS		14. MOTHER'S MAIDEN NAME NANCY SMITH	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 11	
17. INFORMANT MEMORIAL HOSPITAL - CUMBERLAND, MD.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Mesenteric Thrombosis 570.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic Myocarditis DUE TO (c) Dehydration INTERVAL BETWEEN ONSET AND DEATH 2 days 2 yrs			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Oct. 2, 1957 to Oct 5, 1957 , that I last saw the deceased alive on Oct. 5, 1957 , and that death occurred at 8:30 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Cumberland DATE SIGNED 10/6/57			
ACTUAL SIGNATURE Clay E. Durrett M.D.		PHYSICIAN'S NAME (Type) DR. CLAY E. DURRETT	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/8/57	
22c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park		22d. LOCATION (City, town, or county) (State) Cumberland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE John J. Hafar		24. REC'D BY REGISTRAR Oct 8, 1957	
ADDRESS Cumberland, Md.		24b. REGISTRAR'S SIGNATURE A. Ross Cameron, M.D. Acting Registrar	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

STATE OF NEW YORK

BUREAU VI

OT 10 1957

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No.

4

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FLINTSTONE, rural	
c. LENGTH OF STAY IN 1b 98 DAYS		d. STREET ADDRESS 1 Rt # 1	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First JANE Middle ANGELLATTA Last ANGELLATTA		4. DATE OF DEATH Month OCTOBER Day 21 Year 1957	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-27-1915
9. AGE (In years last birthday) 42 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY House	
11. BIRTHPLACE (State or foreign country) MD. Cumberland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME MICHAEL MINKE		14. MOTHER'S MAIDEN NAME ELIZABETH ESCHEBACHER	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Memorial Hospital Cumberland, Md		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Cervix - Advanced 171x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) with abdominal metastasis DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 2 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) October		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April , 19 56 , to October 21 , 19 57 , that I last saw the deceased alive on October 21 , 19 57 , and that death occurred at 5:30 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Cumberland Md DATE SIGNED Oct 22 '57			
ACTUAL SIGNATURE Wm Fawcett		M.D. Cumberland Md	
PHYSICIAN'S NAME (Type) DR. W. FAW			
22a. BURIAL, CREMATION, REBURY (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
Burial	Oct 23 1957	Greenmount Cemetery	Cumberland, Md
23. FUNERAL DIRECTOR'S SIGNATURE Byron Knight		ADDRESS Cumberland, Md.	
24a. REC'D BY REGISTRAR Oct 22, 1957		24b. REGISTRAR'S SIGNATURE W. Ross Cameron, M.D. <i>Acting Registrar</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

WYOMING

WYOMING

CIVIL HOSPITAL

OCTOBER 21

WYOMING

1917

EDWARD J. COHEN

Male

BUREAU V. S.

OCT 28 1917

RECEIVED

10047

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ALLEGANY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE WEST. VIRGINIA b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND,				c. LENGTH OF STAY IN 1b 1 DAY			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL				d. STREET ADDRESS LAURELDALE 85x-3			
3. NAME OF DECEASED (Type or print) First Middle Last BABY GIRL AYERS				4. DATE OF DEATH Month Day Year OCTOBER 6 19 57			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH OCTOBER 6, 1957	
9. AGE (In years last birthday) 8 HRS.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		11. BIRTHPLACE (State or foreign country) CUMBERLAND, MD.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME WILLIAM GLENN AYERS				14. MOTHER'S MAIDEN NAME MARY E. WEASENFORTH			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT MEMORIAL HOSPITAL		Address CUMBERLAND, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 761.0 Sudden Infant Death DUE TO Fetal Gravidia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Retroploental hematoma DUE TO (c) Retroploental hematoma							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month. Day. Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 10/6 PM	
20f. (City or town) 10/6 PM				20g. (County) 10/6 PM		20h. (State) 10/6 PM	
21. I certify that I attended the deceased from 10/6 PM , 19 57 , to 10/6 PM , 19 57 , that I last saw the deceased alive on 6 PM 10/6 1957 , and that death occurred at 8:40 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE Paris Roedel				M.D.			
PHYSICIAN'S NAME (Type) LOUIS MOULD							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10-8-1957		22c. NAME OF CEMETERY OR CREMATORY Idleman Cem.		22d. LOCATION (City, town, or county) (State) Scheer, W. Va.	
23. FUNERAL DIRECTOR'S SIGNATURE Charles L. George				ADDRESS Cumberland, Md.		24a. REC'D BY REGISTRAR Oct. 8, 1957	
				24b. REGISTRAR'S SIGNATURE W.R. Frank, M.D.			

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2060234XVI

BUREAU V. S.

OCT 10 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10046

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

10110

1. PLACE OF DEATH a. COUNTY Allegany <div style="text-align: right;">MARYLAND</div>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westernport	c. LENGTH OF STAY IN 1b 43	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westernport	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 102 Cromer St.		d. STREET ADDRESS 102 Cromer St.	
3. NAME OF DECEASED (Type or print) <div style="text-align: center;">First Middle Last George Conrod Beck</div>		4. DATE OF DEATH Month Day Year Oct. 16 19 57	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED <input type="checkbox"/>	8. DATE OF BIRTH July 12-1882
9. AGE (In years last birthday) 75 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Millwright-W.Va. Pulp & Paper Co.		10b. KIND OF BUSINESS OR INDUSTRY Wleeling, W.Va.	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Henry Beck		14. MOTHER'S MAIDEN NAME Francis Geiger	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes		16. SOCIAL SECURITY NO. W.W.1 & Spn-216-07-2360	
17. INFORMANT (Sister)* Elizabeth Beck, Westernport, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute myocardial failure 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Myocardial infarction DUE TO (c) Coronary sclerotic occlusion.			INTERVAL BETWEEN ONSET AND DEATH sudden ? ?
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined monner <input type="checkbox"/>			
ACTUAL SIGNATURE H.V. Deming M.D.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) H.V. Deming M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Oct. 16-1957	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct. 19-1957	
22c. NAME OF CEMETERY OR CREMATORY Piedmont Cemetery		22d. LOCATION (City, town, or county) (State) Westernport Md.	
23. FUNERAL DIRECTOR'S SIGNATURE H. H. Fredlock Jr.		ADDRESS Piedmont, W. Va.	
		24. REC'D BY REGISTRAR Oct 21 1957	
		24b. REGISTRAR'S SIGNATURE J. C. Kelly	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

OCT 21 1957

RECEIVED

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10045

10048

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland	c. LENGTH OF STAY IN 1b 7 Years	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 618 Maryland Ave		d. STREET ADDRESS 618 Maryland Ave	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Adele Middle Beardsley Last Beardsley		4. DATE OF DEATH Month October Day 24 Year 19 57	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept 9 1872
9. AGE (In years lost birthday) 85 yrs.		IF UNDER 1 YEAR Months 8 Days 19 Hours 57	IF UNDER 24 HRS. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House	10b. KIND OF BUSINESS OR INDUSTRY House Wife	11. BIRTHPLACE (State or foreign country) UNKNOWN	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME UNKNOWN		14. MOTHER'S MAIDEN NAME UNKNOWN	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. None	17. INFORMANT Address Mrs. James Manning, Cumberland, Md.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage DUE TO Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Ravages of age DUE TO (c) Ravages of age			INTERVAL BETWEEN ONSET AND DEATH 48 hrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. — 19 p. m. —	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 10/23/57 , 19 57 , to 10/24/57 , 19 57 , that I last saw the deceased alive on 10/23/57 , 19 57 , and that death occurred at 130 P.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE R. J. Williams M.D.		ADDRESS (Street, city or town, state) Cumberland DATE SIGNED 10/24/57	
PHYSICIAN'S NAME (Type) R. J. Williams, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Oct 26 1957	22c. NAME OF CEMETERY OR CREMATORY Lakewood Burial Park	22d. LOCATION (City, town, or county) (State) Lakewood, Ohio
23. FUNERAL DIRECTOR'S SIGNATURE William H. Knight		ADDRESS Cumberland, Md.	24a. REC'D BY REGISTRAR Oct 26, 1957 24b. REGISTRAR'S SIGNATURE W. R. Frank, M. D.

1957 29 OCT

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please
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or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

101111

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10047

Reg. Dist. No.

9

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Allegany</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frostburg</u>		c. LENGTH OF STAY IN 1b <u>x2 Eckhart</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Fairview St.</u>		d. STREET ADDRESS <u>1</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Laura</u> Middle <u>Jane</u> Last <u>Beeman</u>		4. DATE OF DEATH Month <u>Oct.</u> Day <u>8</u> Year <u>19 57</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 27-1891</u>
9. AGE (In years last birthday) <u>66</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>	
11. BIRTHPLACE (State or foreign country) <u>Loartown, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Isaac Horton</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Belle Henry</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMANT <u>(son) James G. Beeman, Frostburg, Md.</u>		Address <u>Fairview St.,</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary sclerosis</u> DUE TO (c) <u>Arteriosclerosis with hypertention.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u> <u>?</u> <u>?</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> o. m. <u> </u> p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>H. V. Deming M.D.</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>H. V. Deming M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>Oct. 9-1957</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10-11-57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Frostburg Memorial Park</u>		22d. LOCATION (City, town, or county) (State) <u>Frostburg Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Beulah H. Montecant</u>		24a. REC'D BY REGISTRAR <u>23 E. Main, Frostburg, Md.</u>	
		24b. REGISTRAR'S SIGNATURE <u>Oct-18-57 Miss Nancy N. Rose</u>	

BUREAU V. S.

OCT 23 1957

RECEIVED

10049

CERTIFICATE OF DEATH

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

M

60

I

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. LENGTH OF STAY IN 1b 1 HOUR			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First LINA Middle ROSE Last BELL				4. DATE OF DEATH Month OCTOBER Day 5 Year 57			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH AUGUST 13, 1884	
9. AGE (In years last birthday) 73 yrs.		IF UNDER 1 YEAR Months 73		IF UNDER 24 HRS. Days 73 Hours 73 Min. 73			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Own home		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME LEONARD BRANT				14. MOTHER'S MAIDEN NAME NANCY RICE			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. None			
17. INFORMANT MEMORIAL HOSPITAL - CUMBERLAND, MD.				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) acute myocardial infarction 420.0 DUE TO arteriosclerotic heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized arteriosclerosis (c) Generalized arteriosclerosis							
INTERVAL BETWEEN ONSET AND DEATH 24 hours							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 5 Oct. 57 to 5 Oct. 57 19____, that I last saw the deceased alive on 5 Oct. 57 19____, and that death occurred at 5:00 P. M. from the causes and on the date stated above.							
ACTUAL SIGNATURE W. Alfred Van Orman				DATE SIGNED 8 Oct. 57			
PHYSICIAN'S NAME (Type) DR. GEORGE M. SIMONS				ADDRESS (Street, city or town, state) 1225 Centre St. Cumberland, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10-8-1957		22c. NAME OF CEMETERY OR CREMATORY Zion Memorial Cemetery		22d. LOCATION (City, town, or county) (State) Cumberland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Byron Kight				ADDRESS Cumberland, Md.			
24a. RECD BY REGISTRAR Oct. 8, 1957				24b. REGISTRAR'S SIGNATURE W. R. Cameron, M.D. Acting Registrar			

CERTIFICATE OF DEATH

NAME: [REDACTED] SEX: [REDACTED] AGE: [REDACTED] RACE: [REDACTED]
 PLACE OF BIRTH: [REDACTED] DATE OF BIRTH: [REDACTED]
 OCCUPATION: [REDACTED] CAUSE OF DEATH: [REDACTED]
 PLACE OF DEATH: [REDACTED] DATE OF DEATH: [REDACTED]
 SIGNATURE OF DECEASED: [REDACTED] SIGNATURE OF WITNESS: [REDACTED]
 SIGNATURE OF PHYSICIAN: [REDACTED] SIGNATURE OF CLERK: [REDACTED]
 OFFICIAL USE ONLY: [REDACTED]

BUREAU V. N.

OCT 10 1957

RECEIVED

DR. GEORGE M. SIMONS

10-10-57

STATE DEPT.

10050 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10049

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

M

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Allegany		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 1 day		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 Cumberland	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Sacred Heart Hospital			d. STREET ADDRESS 132 Frederick St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Florence Middle Isabell Last Bonner			4. DATE OF DEATH Month Oct. Day 6 Year 19 57		
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 7-1895	9. AGE (In years last birthday) 62 yrs.	IF UNDER 1 YEAR Months 0 Days 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Tucker Co., W. Va.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME Jacob B. Johnson		
14. MOTHER'S MAIDEN NAME Alice white			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		
16. SOCIAL SECURITY NO. None			17. INFORMANT Sacred Heart Hospital records.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Anasarca about 24 hrs. 581.0 DUE TO Conditions, if any, which gave rise to immediate cause (b) Cirrroses of liver (c) ? DUE TO (a), stating the underlying cause last.					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ?					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Cumberland	(County) Md.	(State)
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE H. V. Deming M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) H. V. Deming M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct. 8, 1957		22c. NAME OF CEMETERY OR CREMATORY Davis Memorial Cemetery	
22d. LOCATION (City, town, or county) Cumberland, Md.		22e. (State) Md.		22f. (County)	
23. FUNERAL DIRECTOR'S SIGNATURE Charles L. George, Cumberland, Md.		24a. REC'D BY REGISTRAR Oct. 8, 1957		24b. REGISTRAR'S SIGNATURE W. Ross Cameron, M.D. <i>Acting Registrar</i>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

OCT 10 1957

BUREAU V. 4

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1957

Within Corporate Limits

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10051 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10050

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Allegany</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>02 Cumberland</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Memorial Hospital</u>				d. STREET ADDRESS <u>181 N.Center St.</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Effie M. Brant</u>			4. DATE OF DEATH Month Day Year <u>Oct. 27 19 57</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 1-1875</u>		9. AGE (In years last birthday) <u>82</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Cumberland, Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			13. FATHER'S NAME <u>Daniel Wolford</u>		
14. MOTHER'S MAIDEN NAME <u>Unknown</u>			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		
16. SOCIAL SECURITY NO. <u>none</u>			17. INFORMANT <u>(daughter) Mrs. A. L. Hughes, Cumberland, Md.</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute congestive heart failure</u> about <u>6 hrs.</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Arteriosclerotic heart disease</u> 1 yr. (a), stating the underlying cause lost. DUE TO (c) <u>Generalized arteriosclerosis</u> ? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <u>Cumberland</u>		20g. (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>H. V. Deming M.D.</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <u>H. V. Deming M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Oct. 30, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Greenmount Cemetery</u>	
22d. LOCATION (City, town, or county) <u>Cumberland, Maryland.</u>		22e. (State)			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Louis Stein, Inc., Cumberland, Maryland.</u>		ADDRESS		24a. REG'D BY REGISTRAR <u>Oct. 29, 1957</u>	
24b. REGISTRAR'S SIGNATURE <u>W. Ross Cameron, M.D.</u>		Acting Registrar			

STATE
HEALTH DEPT

RECORDS STATE DEPARTMENT OF HEALTH - BALTIMORE, MD
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

MANNER OF DEATH

AGE

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

PREVIOUS ILLNESS

PREVIOUS SURGERY

PREVIOUS TRAUMA

PREVIOUS DRUGS

PREVIOUS ALCOHOL

PREVIOUS TOBACCO

PREVIOUS OTHER

PREVIOUS OTHER

PREVIOUS OTHER

PREVIOUS OTHER

PREVIOUS OTHER

PREVIOUS OTHER

BUREAU V. S.

OCT 30 1917

RECEIVED

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10052

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10051

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Allegany		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 6 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 Cumberland	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 701 Baker St.			d. STREET ADDRESS 1 701 Baker St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Clinton Middle Sylvester Last Brown			4. DATE OF DEATH Month Oct. Day 6 Year 19 57		
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 12-1883		9. AGE (in years last birthday) 74 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired). Retired Stationary *Cumberland Steel Co.		10b. KIND OF BUSINESS OR INDUSTRY Cedar Creek, Va.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Brown			14. MOTHER'S MAIDEN NAME Eliza Coffman		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 214-07-1329		17. INFORMANT (wife) Mary E.M. Brown, Cumberland, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 Coronary occlusion DUE TO (b) Arteriosclerotic heart disease Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. Arteriosclerosis with hypertention.					INTERVAL BETWEEN ONSET AND DEATH sudden about 3 years 11
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour 19 o. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE H.V. Deming M.D.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) H.V. Deming M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct. 11, 1957		22c. NAME OF CEMETERY OR CREMATORY St. Patrick's Cemetery	
22d. LOCATION (City, town, or county) Cumberland, Maryland.		22e. REC'D BY REGISTRAR Oct. 8, 1957		24b. REGISTRAR'S SIGNATURE W. Ross Cameron, M.D. <i>Acting Registrar</i>	
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli, Cumberland, Maryland.		ADDRESS 8 Sample St.			

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RECEIVED

OCT 10 1957

BUREAU V. 1

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TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The information copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this death certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

CERTIFICATE OF DEATH

Reg. Dist. No. 6

10130

1. PLACE OF DEATH COUNTY Allegany CITY (If outside corporate limits, write RURAL and give nearest town) McCoole TOWN HOSPITAL OR INSTITUTION OR STREET ADDRESS 32 Howard Street		2. USUAL RESIDENCE (HOME) OF DECEASED STATE W.Va. COUNTY Mineral CITY (If outside corporate limits, write RURAL and give nearest town) Rural- Laurel Dale TOWN STREET ADDRESS (If rural give location)	
3. NAME OF DECEASED (Type or Print) Rosa Lee Burgess (First) (Middle) (Last)		4. DATE OF DEATH (Month) (Day) (Year) October 1, 1957	
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Nov. 25, 1905
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY Own home	9. AGE last birthday 51 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS. Hours Min.
11. BIRTHPLACE (State or foreign country) Hartmansville, W.Va.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Benjamin Franklin McNemar		14. MOTHER'S MAIDEN NAME Mary Magdalene Heishman	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or yes) (If Yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 235-60-3350	
17. INFORMANT & ADDRESS Albert Burgess-Laurel Dale, W.Va.			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 443X IMMEDIATE CAUSE (A) Apoplectic stroke (left side) ANTECEDENT CAUSE(S) DUE TO (B) Essential hypertension DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) Cardio renal vascular disease			INTERVAL BETWEEN ONSET AND DEATH 6 days 18 yrs 18 yrs
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) M. <input type="checkbox"/> Not while at work <input type="checkbox"/> While at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from last 7 or 8 yrs to Oct 1, 1957 , that I last saw the deceased alive on Oct 1, 1957 , and that death occurred at 7:05 A.M. , from the causes and on the date stated above. 10/2/57 SIGNATURE R. E. Everhart M.D. ADDRESS (Street, city, town, state) 525 Natl Hwy Co Vale Cumberland DATE SIGNED 23. BURIAL, CREMATION, REBURYAL (SPECIFY) Burial DATE THEREOF 10/3/57 NAME OF CEMETERY OR CREMATORY Burgess Cemetery LOCATION (City, town, or county) (State) Laurel Dale, Mineral, W.Va 24. REC'D BY REGISTRAR 90-5-57 REGISTRAR'S SIGNATURE Jean C Kelly 25. FUNERAL DIRECTOR'S SIGNATURE O F Sharpless ADDRESS Blaine, W.Va			

CERTIFICATE OF DEATH

REG. NO. 125

IN DEPARTMENT OF HEALTH
BIRMINGHAM, ALABAMA
DECEASED
DATE OF DEATH

DECEASED

DECEASED

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OCT 9 1957

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10053 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

10053

FOR STATE HEALTH DEPT.

1. PLACE OF DEATH
a. COUNTY

Allegany

MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)

a. STATE

Md.

b. COUNTY Allegany

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Cumberland

c. LENGTH OF STAY IN 1b

20 Yrs.

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Cumberland

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

Sacred Heart Hospital

d. STREET ADDRESS

208 Charles St.

e. IS RESIDENCE ON A FARM?
YES ☐ NO ☒

3. NAME OF DECEASED
(Type or print)

First

Mary

Middle

Hazel

Last

Carder

4. DATE OF DEATH

Month

Oct.

Day

22

Year

1957

5. SEX

Female

6. COLOR OR RACE

white

7. MARRIED ☐ NEVER MARRIED ☐

WIDOWED ☐ DIVORCED ☒

8. DATE OF BIRTH

Nov. 6-1898

9. AGE (In years last birthday)

58 yrs.

IF UNDER 1 YEAR

Months

Days

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

10b. KIND OF BUSINESS OR INDUSTRY

Own Home

11. BIRTHPLACE (State or foreign country)

Cumberland, Md.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

George Carder

14. MOTHER'S MAIDEN NAME

Cora Duvall

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)

no

16. SOCIAL SECURITY NO.

216-18-1777

17. INFORMANT

Address

(father) George Carder, Cumberland, Md.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

Myocardial failure

INTERVAL BETWEEN ONSET AND DEATH
1 hr.

443x

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

Cardio-vascular disease with hypertention

?

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

19. WAS AUTOPSY PERFORMED?
YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY

Month, Day, Year

Hour o. m. p. m.

19

20d. INJURY OCCURRED

While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE

H.V. Deming M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐

DATE SIGNED

ASSISTANT MEDICAL EXAMINER ☐

EXAMINER'S NAME (Type)

H.V. Deming M.D.

DEPUTY MEDICAL EXAMINER ☒ Oct. 22-1957

22a. BURIAL, CREMATION, REMOVAL (Specify)

Burial

22b. DATE THEREOF

Oct. 25, 1957

22c. NAME OF CEMETERY OR CREMATORY

Oldtown Cemetery

22d. LOCATION (City, town, or county)

Oldtown, Maryland

(State)

23. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

William H. Kight, Cumberland, Maryland.

24a. REC'D BY REGISTRAR

Oct. 24, 1957

24b. REGISTRAR'S SIGNATURE

W. Ross Cameron, M.D.
Acting Registrar

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

OCT 25 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

M

Rural

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10

MEDICAL CERTIFICATION

2

VS. A15ME
SM 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10131

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10054

Reg. Dist. No.

6

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Allegany</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural-near Dawson-Rt.220</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural-near Dawson Rt.220 x2</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>R.F.D.#3 Keyser, W.Va.</u>		d. STREET ADDRESS <u>R.F.D.#3 Keyser, W.Va.</u>	
3. NAME OF DECEASED (Type or print) First <u>Margarete</u> Middle <u>Carr</u> Last <u>Carr</u>		4. DATE OF DEATH Month <u>Oct.</u> Day <u>20</u> Year <u>19 57</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 11-1888</u>
9. AGE (In years last birthday) <u>69</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	11. IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Elk, W.Va</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Jessie A.Carr</u>		14. MOTHER'S MAIDEN NAME <u>Virginia Heart</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>(husband) Martin Carr, R.F.D.#3 Keyser, W.Va.</u>		Address <u>rural</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>Acute myocardial failure</u> IMMEDIATE CAUSE (a) <u>442x</u> DUE TO <u>Cardio-vascular-renal disease</u> Conditions, if any, which gave rise to immediate cause (b) (c) <u> </u> DUE TO (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u> <u>?</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u> </u>		20c. TIME OF INJURY Month, Day, Year Hour <u> </u> o. m. <u> </u> p. m. <u> </u> 19 <u> </u>	
20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>	
20f. (City or town) <u> </u>		(County) <u> </u> (State) <u> </u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>H.V. Deming M.D.</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>H.V. Deming M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>Oct. 21-1957</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10-23-57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Waxler</u>		22d. LOCATION (City, town, or county) (State) <u>Dawson, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Allen Pottruck</u>		24a. REC'D BY REGISTRAR <u>10-24-57</u>	
ADDRESS <u>Keyser, W.Va.</u>		24b. REGISTRAR'S SIGNATURE <u>John C Kelly</u>	

FOR STATE
HEALTH DEPT

MASSACHUSETTS DEPARTMENT OF HEALTH
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. 3

OCT 25 1957

RECEIVED

1
Within corporate limits

Item 8, Film G222, 10/31/57 fcy

10054

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH a. COUNTY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. LENGTH OF STAY IN 1b 91 DAYS			
d. NAME OF HOSPITAL (If not in hospital, give street address) MEMORIAL HOSPITAL				d. STREET ADDRESS ROUTE 1 BRADDOCK RD.			
3. NAME OF DECEASED (Type or print) First ROSETTA Middle CATLETT Last CATLETT				4. DATE OF DEATH Month OCTOBER Day 17 Year 19 57			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH JULY 15, 1882	
9. AGE (In years last birthday) 74 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>Self/home</i>		11. BIRTHPLACE (State or foreign country) WEST VIRGINIA	
12. CITIZEN OF WHAT COUNTRY? U. S. AMERICA							
13. FATHER'S NAME I. N. MARTIN				14. MOTHER'S MAIDEN NAME <i>Susan Bosley</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. <i>None</i>		17. INFORMANT MEMORIAL HOSPITAL		Address CUMBERLAND	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Accident 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive Arteriosclerotic Cardiovascular Disease DUE TO (c) Advanced Age							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>July</i> , 19 <i>57</i> , to <i>Oct</i> , 19 <i>57</i> , that I last saw the deceased alive on <i>Oct 17</i> , 19 <i>57</i> , and that death occurred at <i>4:10 P</i> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>133 Virginia Ave, Cumberland Md</i> DATE SIGNED <i>10/19/57</i> ACTUAL SIGNATURE <i>[Signature]</i> M.D. <i>[Signature]</i> PHYSICIAN'S NAME (Type) DR. OVERTON HIMMELWRIGHT							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Burial		Oct 20, 1957		Rose Hill Cem		Cumberland Md	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Louis Stein Inc. Crumb Md</i>				24a. REC'D BY REGISTRAR <i>Oct 22, 1957</i>		24b. REGISTRAR'S SIGNATURE <i>W. Ross Cameron, M.D. Acting Registrar</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 7 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH	
JAMES H. SMITH		MALE		45		JAN 15 1910		BALTIMORE, MARYLAND	
RESIDENCE		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		PLACE OF DEATH	
1234 E. BALTIMORE		CLERK		HEART DISEASE		NATURAL		HOSPITAL	
DATE OF DEATH		TIME OF DEATH		DOCTOR'S SIGNATURE		HOSPITAL'S SIGNATURE		CITY	
OCT 23 1957		10:15 PM		J. H. SMITH		J. H. SMITH		BALTIMORE	

BUREAU Y. 5

OCT 23 1957

RECEIVED

10055

CERTIFICATE OF DEATH

Reg. Dist. No.

4

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE W. Va. b. COUNTY Mineral			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland,				c. LENGTH OF STAY IN 1b 7 hrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ridgeley 85x-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Sacred Heart Hospital				d. STREET ADDRESS 7 Martin St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Anna Middle Carrie Last Clarke				4. DATE OF DEATH Month 10 Day 1 Year 1957			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov. 22, 1885	
9. AGE (In years last birthday) 71 yrs.		10. IF UNDER 1 YEAR Months 7 Days 1 Hours 1 Min.		11. BIRTHPLACE (State or foreign country) Rainesburg, Penna.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Own home		11. BIRTHPLACE (State or foreign country) Rainesburg, Penna.	
13. FATHER'S NAME Edward Stuckey				14. MOTHER'S MAIDEN NAME Olive Diehl			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 232-09-5878-A		17. INFORMANT Mr. Bernard M. Clarke Address 7 Martin St., Ridgeley, W. Va.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertensive C.V. Disease 443x DUE TO Pulmonary Embolism & Coroner Determination Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Pulmonary Embolism & Coroner Determination DUE TO (c) Pulmonary Embolism & Coroner Determination PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 8 hours INTERVAL BETWEEN ONSET AND DEATH 8 hours							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from Jan 1, 1957 to Oct 1, 1957 that I last saw the deceased alive on Oct 1, 1957 , and that death occurred at 7:29 P. M. from the causes and on the date stated above.							
ACTUAL SIGNATURE B. M. Schindler M.D.				ADDRESS (Street, city or town, state) 43 Greenfield, Cumberland, Md. DATE SIGNED Oct 1, 1957			
PHYSICIAN'S NAME (Type) Blane M. Schindler M. D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/4/57		22c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park		22d. LOCATION (City, town, or county) (State) Cumberland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE H. Wayne George Cumberland, Maryland				24a. REG'D BY REGISTRAR Oct 3, 1957		24b. REGISTRAR'S SIGNATURE W. Ross Cameron, M.D. Acting Registrar	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10

BUREAU V. S.

OCT 4 1957

RECEIVED

10056

CERTIFICATE OF DEATH

Reg. Dist. No.

10057

1. PLACE OF DEATH o. COUNTY <u>Allegany</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>				c. LENGTH OF STAY IN 1b <u>02</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>749 Fayette Street</u>				d. STREET ADDRESS <u>749 Fayette St.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Margaret</u> Middle <u>Chanson</u> Last <u>Chanson</u>				4. DATE OF DEATH Month <u>October</u> Day <u>3</u> Year <u>1957</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov. 22, 1861</u>	
9. AGE (In years last birthday) <u>95</u> yrs.		IF UNDER 1 YEAR Months <u>9</u> Days <u>3</u> Hours <u>15</u> Min.		IF UNDER 24 HRS. Months <u>9</u> Days <u>3</u> Hours <u>15</u> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Perry Co. Pa.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>							
13. FATHER'S NAME <u>John McKee Averill</u>				14. MOTHER'S MAIDEN NAME <u>Sarah Moorhead</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>Miss Ruth A Chanson</u> <u>Cumb. Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic myocardial degeneration</u> <u>592X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cerebral arteriosclerosis</u> DUE TO (c) <u>Chronic hepatitis</u>							INTERVAL BETWEEN ONSET AND DEATH <u>?</u> <u>?</u> <u>?</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Senile deterioration</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>October 1, 1927</u> , to <u>Oct. 31, 1957</u> that I last saw the deceased alive on <u>Oct. 27, 1957</u> , and that death occurred at <u>2:35 P.M.</u> from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) <u>49 Greene St.</u>						DATE SIGNED <u>10/4/57</u>	
ACTUAL SIGNATURE <u>James E. McLean</u>				M.D. <u>49 Greene St.</u>			
PHYSICIAN'S NAME (Type) <u>James E. McLean, M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10/6/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Cumberland Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Louis Stein Inc.</u>				ADDRESS <u>Cumb. Md.</u>		24a. REC'D BY REGISTRAR <u>Oct 5, 1957</u>	
				24b. REGISTRAR'S SIGNATURE <u>W. Ross Cameron, M.D.</u>		Acting Registrar	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

BUREAU V. 3

OCT 8 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										10058	
DR. W.F. WILLIAMS										CERTIFICATE OF DEATH	
Reg. Dist. No. 4											
1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE PENNSYLVANIA b. COUNTY BEDFORD						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND					c. LENGTH OF STAY IN 1b 10 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ARTEMAS 75 x -3				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL					d. STREET ADDRESS					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MORGAN Middle CLINGERMAN Last					4. DATE OF DEATH Month OCTOBER Day 26 Year 1957						
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH DEC. 10, 1867		9. AGE (In years last birthday) 89 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HONORED FARMER				10b. KIND OF BUSINESS OR INDUSTRY OWN FARM		11. BIRTHPLACE (State or foreign country) ARTEMAS, PA.			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME JOSEPH CLINGERMAN					14. MOTHER'S MAIDEN NAME MARY MILLER						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO				16. SOCIAL SECURITY NO.		17. INFORMATION MEMORIAL HOSPITAL - CUMBERLAND, MD.					
18. CAUSE OF DEATH [Enter only one cause pertinent for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Nephritis - uremia 592x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH 10 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 10.16.1957 to 10.26.1957, that I last saw the deceased alive on 10.25.1957, and that death occurred at 6:40 A.M. from the causes and on the date stated above.											
ACTUAL SIGNATURE W.F. Williams M.D.				ADDRESS (Street, city or town, state) Cumberland MD				DATE SIGNED 10.26.57			
PHYSICIAN'S NAME (Type) DR. W.F. WILLIAMS											
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct. 28, 1957		22c. NAME OF CEMETERY OR CREMATORY Fairview Cemetery				22d. LOCATION (City, town, or county) (State) Artemas, Pennsylvania.			
23. FUNERAL DIRECTOR'S SIGNATURE Joseph W. Stewart				ADDRESS Towertown Pa		24a. REC'D BY REGISTRAR Oct 28, 1957		24b. REGISTRAR'S SIGNATURE W. Ross Cameron, M.D. Acting Registrar			

CERTIFICATE OF DEATH

W. H. MILLING

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

See District

DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH	
JULY 28, 1957		HOSPITAL		HEART DISEASE	
TIME OF DEATH		AGE		SEX	
10:00 AM		65 YEARS		MALE	
DATE OF BIRTH		PLACE OF BIRTH		OCCUPATION	
JULY 10, 1892		BALTIMORE, MD.		FARMER	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH	
JULY 28, 1957		HOSPITAL		HEART DISEASE	
TIME OF DEATH		AGE		SEX	
10:00 AM		65 YEARS		MALE	
DATE OF BIRTH		PLACE OF BIRTH		OCCUPATION	
JULY 10, 1892		BALTIMORE, MD.		FARMER	

BUREAU V. 2

JUL 29 1957

RECEIVED

Within corporate limits

10058

CERTIFICATE OF DEATH

Reg. Dist. No.

4

1. PLACE OF DEATH o. COUNTY <u>Allegany</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>				c. LENGTH OF STAY IN 1b <u>3 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Sacred Heart Hospital</u>				d. STREET ADDRESS <u>702 N. Centre St.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Morris</u> Middle <u>L.</u> Last <u>Cohen</u>				4. DATE OF DEATH Month <u>October</u> Day <u>21</u> Year <u>19 57</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1/10/86</u>	
9. AGE (In years last birthday) <u>71</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Foreman - American Viscose Company</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Germany</u>		11. BIRTHPLACE (State or foreign country) <u>USA</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>Michael Cohen</u>				14. MOTHER'S MAIDEN NAME <u>Esther ---Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>177-034-218</u>		17. INFORMANT <u>Mrs. Guy Long, 702 N. Centre St., Cumberland, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinomatosis</u> <u>199.9</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u> (b) <u> </u> (c) <u> </u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u> </u> p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>9/25</u> , 19 <u>57</u> , to <u>10/21</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>10/21</u> , 19 <u>57</u> , and that death occurred at <u>4:00 P.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u> </u> DATE SIGNED <u>10/21/57</u>							
ACTUAL SIGNATURE <u>Leo H. Ley Jr.</u> M.D.							
PHYSICIAN'S NAME (Type) <u>Leo H. Ley, M.D.</u>				<u>456 N. Centre St., Cumberland, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Oct. 23, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>East View Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Cumberland, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>James F. Scarpelli, Cumberland, Maryland.</u>				24a. REC'D BY REGISTRAR <u>Oct 23, 1957</u>		24b. REGISTRAR'S SIGNATURE <u>W. Ross Cameron M.D.</u> <u>Acting Registrar</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

State of Maryland

Place of Birth

Residence

Occupation

Marital Status

Cause of Death

Time of Death

Place of Death

Age at Death

Sex

Color

Religion

Ethnic Group

Education

Service

Remarks

Signature

Date

Time

Place

Age

Sex

Color

Religion

Ethnic Group

Education

Service

Remarks

Signature

Date

Time

Place

Age

Sex

Color

Religion

Ethnic Group

Education

Service

BUREAU V. 3

OCT 24 1957

RECEIVED

10059

CERTIFICATE OF DEATH

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland				c. LENGTH OF STAY IN 1b 9/4/57			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Allegany County Infirmary				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Effie Middle May Last Compton				4. DATE OF DEATH Month October Day 28 Year 19 57			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6/16/1879	
9. AGE (In years last birthday) 78 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Richard Mankameyer				14. MOTHER'S MAIDEN NAME Ida Witt			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. None			
17. INFORMANT P.O.Box 599 Address Cumberland, Md.				18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 4222 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic Myocarditis (c) Cerebral arteriosclerosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Left Hemiplegia			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19			
20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)				21. I certify that I attended the deceased from 9/4/57 , 19 57 , to 10/28/57 , 19 57 , that I last saw the deceased alive on 10/28/57 , 19 57 , and that death occurred at 6:25 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 49 Greene St. Cumberland, Md. DATE SIGNED 10/29/57			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 10/31/57			
22c. NAME OF CEMETERY OR CREMATORY White Oak Cem.				22d. LOCATION (City, town, or county) (State) Meyersdale, Penna.			
23. FUNERAL DIRECTOR'S SIGNATURE H. R. Konhaus *				24a. REC'D BY REGISTRAR Oct 31, 1957			
24b. REGISTRAR'S SIGNATURE W. Ross Cameron, M.D. <i>Acting Registrar</i>							

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Richard Lankford

2024 2023

922-201-575

BUREAU V. 1

1957 1 NOV

RECEIVED

10060

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland				c. LENGTH OF STAY IN 1b 50 years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 207 Polk St.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First ANNA Middle C. Last CONNOR				4. DATE OF DEATH Month Oct. Day 10, Year 1957			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 29, 1872	9. AGE (In years last birthday) 85 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Solomon Rizer				14. MOTHER'S MAIDEN NAME Rachael Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Address Earl Connor, Cumberland, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic myocarditis 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerosis DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH 2 years 3 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Oct 9 , 19 57 , to Oct 10 , 19 57 , that I last saw the deceased alive on Oct 9 , 19 57 , and that death occurred at 10 A. M, from the causes and on the date stated above.							
ACTUAL SIGNATURE R. W. Trevaskis, Jr.				ADDRESS (Street, city or town, state) Cumberland, Md.			
PHYSICIAN'S NAME (Type) R. W. TREVASKIS, JR.				DATE SIGNED Oct 11-57			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10-12-1957		22c. NAME OF CEMETERY OR CREMATORY Hill Crest Cemetery		22d. LOCATION (City, town, or county) (State) Cumberland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Byron Kight				ADDRESS Cumberland, Maryland		24a. REC'D BY REGISTRAR DATE Oct 12, 1957	
				24b. REGISTRAR'S SIGNATURE W. Ross Cameron, M.D.		Acting Registrar	

RECEIVED
OCT 15 1957
BUREAU V. S.

OCT 15 1967

BUREAU V. S.

Within 10 days

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10062

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10061

Reg. Dist. No. 4

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> <u>MARYLAND</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Allegany</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>		c. LENGTH OF STAY IN 1b <u>50 Yrs.</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>02 Cumberland</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>208 Knox St.</u>			d. STREET ADDRESS <u>208 Knox St.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Charles</u> Middle <u>Austin</u> Last <u>Cook</u>			4. DATE OF DEATH Month <u>Oct.</u> Day <u>22</u> Year <u>19 57</u>		
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 2-1874</u>		9. AGE (In years last birthday) <u>83</u> yrs.
			IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Engineer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>B&O.R.Ry.</u>		11. BIRTHPLACE (State or foreign country) <u>Wellersburg, Pa.</u>	
				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Soloman Cook</u>			14. MOTHER'S MAIDEN NAME <u>Martha ---Unknown</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>(wife) Sadie Cook, Cumberland, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Coronary sclerosis</u> (a), stating the underlying cause last. (c) <u>Arteriosclerosis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u> <u>?</u> <u>?</u>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>H. V. Deming M.D.</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <u>H.V. Deming M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		<u>Oct. 23-1957</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Oct. 25, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Hillcrest Burial Park</u>	
				22d. LOCATION (City, town, or county) (State) <u>Cumberland, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William H. Kight, Cumberland, Maryland.</u>			24a. REC'D BY REGISTRAR <u>Oct. 24, 1957</u>		
			24b. REGISTRAR'S SIGNATURE <u>W. Ross Cameron, M.D.</u> <u>Acting Registrar</u>		

RECEIVED
OCT 25 1957
BUREAU V. 8

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

10063

Reg. Dist. No.

10132

Outside of
City Limits

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural, Cumberland				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Route 4, Oldtown Road				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Harry Middle Mason Last Davis				4. DATE OF DEATH Month October Day 26 Year 1957 19			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug. 7, 1872	
9. AGE (In years last birthday) 85 yrs.		10. AGE (In years last birthday) 85 yrs.		11. BIRTHPLACE (State or foreign country) Spring Gap, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer				10b. KIND OF BUSINESS OR INDUSTRY General Farming			
13. FATHER'S NAME Amos Davis				14. MOTHER'S MAIDEN NAME Sarah L. Little			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. None		17. INFORMANT Cora H. Davis, Rt. 4, Oldtown Road, Cumberland, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 592X DUE TO Memoria Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) chronic nephritis DUE TO (c) 13cm PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) generalized atherosclerosis 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Allegany				20g. (County) Allegany		20h. (State) Maryland	
21. I certify that I attended the deceased from 10-4-1957 to 10-26-1957 , that I last saw the deceased alive on 10-16-1957 , and that death occurred at 6 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 57 Greene St., Cumberland, Md. DATE SIGNED 10/29/57 ACTUAL SIGNATURE [Signature] M.D. [Signature] PHYSICIAN'S NAME (Type) Lewis Briggs M.D. 57 Greene Street, Cumberland, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 1-29-57		22c. NAME OF CEMETERY OR CREMATORY Davis Memorial Cemetery	
22d. LOCATION (City, town, or county) Allegany County, Maryland				22e. (State) Maryland		22f. (County) Allegany	
23. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer, Cumberland, Maryland				24. REC'D BY REGISTRAR Oct. 29, 1957		24b. REGISTRAR'S SIGNATURE [Signature]	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician and completely filled in by the funeral director. Pages 1 and 2 should be filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, the page could be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled in by the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 10

Reside

City

DATE

TIME

PLACE

CAUSE

MANNER

AGE

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

Marital Status

Previous Illnesses

Drugs Taken

Alcohol Consumed

Tobacco Used

Other Habits

Signature of Physician

Signature of Registrar

Signature of Informant

Signature of Coroner

Signature of Medical Examiner

Signature of Pathologist

Signature of Forensic Scientist

Signature of Toxicologist

Signature of Anthropologist

Signature of Archaeologist

Signature of Linguist

Signature of Historian

Signature of Geographer

Signature of Meteorologist

Signature of Astronomer

Signature of Physicist

Signature of Chemist

Signature of Biologist

Signature of Ecologist

Signature of Environmental Scientist

Signature of Health Scientist

Signature of Public Health Officer

Signature of Epidemiologist

Signature of Infectious Disease Specialist

Signature of Immunologist

Signature of Microbiologist

Signature of Virologist

Signature of Bacteriologist

Signature of Parasitologist

BUREAU V. R.

OCT 30 1957

RECEIVED

10062

CERTIFICATE OF DEATH

10064

Reg. Dist. No. 4

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland				c. LENGTH OF STAY IN 1b 02 Cumberland			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1000 Frederick St				d. STREET ADDRESS 1000 Frederick St.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Mary Middle Elizabeth Last De Vault				4. DATE OF DEATH Month October Day 17 Year 19 57			
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 31, 1877		9. AGE (In years last birthday) 80 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own home		11. BIRTHPLACE (State or foreign country) Lonaconing, Md		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Samuel Mills				14. MOTHER'S MAIDEN NAME Sarah Ann Nightengale			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs. James F. Shankoltz, Cumberland, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hodgkins Disease 201X DUE TO Thrombia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH 3 wks	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from June 1957 to Oct. 17, 1957 , that I last saw the deceased alive on Oct 17, 1957 and that death occurred at 4:00 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Clay E. Durrett M.D.				DATE SIGNED 10/19/57			
PHYSICIAN'S NAME (Type) Clay E. Durrett							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/20/ 57		22c. NAME OF CEMETERY OR CREMATORY Oak Hill Cemetery		22d. LOCATION (City, town, or county) (State) Lonaconing, Md	
23. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer, Cumberland, Maryland				24a. REC'D BY REGISTRAR Oct 19, 1957		24b. REGISTRAR'S SIGNATURE W. Ross Cameron, M.D. <i>Acting Registrar</i>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

OCT 22 1957

RECEIVED

Within corporate limits

10063 CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) x2 Cumberland, Rural	
c. LENGTH OF STAY IN 1b 6/10/57		d. STREET ADDRESS Rt. #3, Bedford Road	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Allegany County Infirmary		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First John Middle W. Last Dickerhoof		4. DATE OF DEATH Month October Day 17 , Year 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/10/1872
9. AGE (In years last birthday) 84.25 Yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired - Bridge		10b. KIND OF BUSINESS OR INDUSTRY Builder	
11. BIRTHPLACE (State or foreign country) Cumberland, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Joseph L. Dickerhoof		14. MOTHER'S MAIDEN NAME Henrietta Rank	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. —	
17. INFORMANT P.O. Box 599 Address Cumberland, Md.		18. ALLEGANY COUNTY INFIRMARY RECORDS	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Hypostasis			36 hrs.
DUE TO Chronic Myocarditis			?
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cerebral Arteriosclerosis			?
DUE TO (c) Chronic Nephritis			?
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL-DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 6/10/57 , 19___, to 10/17/57 , 19___, that I last saw the deceased alive on 10/17/57 , 19___, and that death occurred at ___ M, from the causes and on the date stated above.			
ACTUAL SIGNATURE J. E. McLean M.D.		ADDRESS (Street, city or town, state) 49 Greene St. DATE SIGNED 10/18/1957	
PHYSICIAN'S NAME (Type) Dr. J. E. McLean,		Cumberland, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
Burial	Oct 20, 1957	St. Luke's Cem.	Cumberland Md.
23. FUNERAL DIRECTOR'S SIGNATURE Louis Stein Inc. ADDRESS Cumb. Md.		24a. REC'D BY REGISTRAR Oct 22, 1957	24b. REGISTRAR'S SIGNATURE W.R. Frank, M.D.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Name of Deceased		John W. Dickerson	
Sex		Male	
Race		White	
Date of Birth		6/10/1872	
Place of Birth		Guthrie, Maryland	
Date of Death		10/10/1957	
Place of Death		St. Elizabeth's Hospital, Baltimore, Maryland	
Cause of Death		Coronary Thrombosis	
Occupation		Retired - Bridge Builder	
Marital Status		Married - Bridge	
Signature of Physician		Joseph L. Dickerson	
Signature of Registrar		Hester Bank	
Signature of Informant		I.O. Box 899	
Address of Informant		Allegany County Jail, West Virginia	

BUREAU V. 3

OCT 10 1957

RECEIVED

10133

CERTIFICATE OF DEATH

Reg. Dist. No.

9

1. PLACE OF DEATH o. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Midlothian,				c. LENGTH OF STAY IN 1b 40 yrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) x2 Midlothian,			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS 1		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Pearl Middle B. Last Dudley				4. DATE OF DEATH Month Oct. Day 4th Year 1957			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 1st, 1891	
9. AGE (In years lost birthday) 66 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Own Housework		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME George Bennett				14. MOTHER'S MAIDEN NAME Jessie Nichol			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (!! yes, give war or dates of service)		16. SOCIAL SECURITY NO. None		17. INFORMANT John Dudley,		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Malignant Hypertension 446x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Malignant Hypertension DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH 3 weeks
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Anemia, Obesity							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 1955 to Oct 4, 1957 that I last saw the deceased alive on Sept 30, 1957 , and that death occurred at 3 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE John C. Burns M.D.				ADDRESS (Street, city or town, state) 131 E. Main			
PHYSICIAN'S NAME (Type) John C. Burns				DATE SIGNED 10/4/57			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10-6-1957		22c. NAME OF CEMETERY OR CREMATORY Eckhart Cemetery		22d. LOCATION (City, town, or county) (State) Eckhart, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Joseph R. Durst,				ADDRESS Frostburg, Md.		24a. REC'D BY REGISTRAR DATE 10-6-57	
				24b. REGISTRAR'S SIGNATURE Miss Nancy H. Rose			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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CERTIFICATE OF DEATH

MARYLAND STATE DEPT. OF HEALTH - BALTIMORE, MD.

FILE NO.

BUREAU V. S.

OCT 11 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10064

CERTIFICATE OF DEATH

Reg. Dis.

10067

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE W. Va. b. COUNTY Morgan	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 1 week	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Sacred Heart Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Thomas Middle J. Last Duvall		4. DATE OF DEATH Month Oct. Day 4 Year 1957	
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 4, 1897
9. AGE (In years last birthday) 60 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Railroad Signalman		10b. KIND OF BUSINESS OR INDUSTRY Railroad	
11. BIRTHPLACE (State or foreign country) VIRGINIA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Joseph Duvall		14. MOTHER'S MAIDEN NAME Martha Madden	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs Lulu Grace Duvall, Paw Paw, W. V		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 442x Apoplectic stroke left side DUE TO (b) Cardio renal vascular disease DUE TO (c) 5 years Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH 5 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. — 19 p. m. —		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept 2, 1957 , to Oct 4, 1957 , that I last saw the deceased alive on Oct 4, 1957 , and that death occurred at 10:07 A.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Lysle R. Everhart		ADDRESS (Street, city or town, state) 125 N. Main Hwy. Co. Vale	
PHYSICIAN'S NAME (Type) LYSLE R. EVERHART, M.D.		DATE SIGNED Cumberland Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/6/57	
22c. NAME OF CEMETERY OR CREMATORY Forest Glen		22d. LOCATION (City, town, or county) (State) Greenspring, W. Va.	
23. FUNERAL DIRECTOR'S SIGNATURE Charles F. Horner		24a. REC'D BY REGISTRAR W. Ross Cameron M.D.	
ADDRESS Berkley Spg.		DATE Oct. 7, 1957	
		24b. REGISTRAR'S SIGNATURE Acting Registrar	

MEDICAL CERTIFICATION

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CERTIFICATE OF DEATH

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MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BOSTON

FILE NO. 100-100000

100-100000

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BOSTON

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BOSTON

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MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BOSTON

BUREAU V. 2

OCT 10 1957

RECEIVED

100-100000

CERTIFICATE OF DEATH

10065

10068

Reg. Dist. No.

4

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 22 65 E. Main St., Frostburg, Md.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Allegany County Infirmary		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Leslie Middle Eisel Last Eisel		4. DATE OF DEATH Month October Day 15 Year 19 57	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/9/1904
9. AGE (In years last birthday) 53 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired - Laborer		10b. KIND OF BUSINESS OR INDUSTRY W.Md.Railway	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME George Eisel		14. MOTHER'S MAIDEN NAME Sarah Gunter	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 712-14-1663	
17. INFORMANT P.O.Box 599		Address Cumberland, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Sclerosis 241X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic Myocarditis DUE TO (c) Bronchial Asthma		INTERVAL BETWEEN ONSET AND DEATH Sudden ? ?	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Gen. Arteriosclerosis			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 11/23/56 19____, to 10/15/57 19____, that I last saw the deceased alive on 10/14/57 19____, and that death occurred at 9:15 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 49 Greene St. DATE SIGNED 10/15/57			
ACTUAL SIGNATURE J. E. McLean		M.D. 49 Greene St.	
PHYSICIAN'S NAME (Type) Dr. J. E. McLean		Cumberland, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 10-17-57	22c. NAME OF CEMETERY OR CREMATORY F'bg.Memorial Park	22d. LOCATION (City, town, or county) (State) Frostburg, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Joseph R. Durst,		ADDRESS Frostburg, Md.	
24a. REC'D BY REGISTRAR Oct. 17, 1957		24b. REGISTRAR'S SIGNATURE W. J. Cameron M.D. <i>Acting Registrar</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

— 200 —

02/05/11

1990 1991 1992 1993

• <http://www.bna-fischer.com>

BUREAU V. S.

18 OCT 1957

RECEIVED

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg		c. LENGTH OF STAY IN 1b 6 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Miners Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Midland	
3. NAME OF DECEASED (Type or print) First Lee Middle Ann Last Fair		4. DATE OF DEATH Month October Day 29 Year 19 57	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 25, 1947
9. AGE (In years lost birthday) 10 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		10b. KIND OF BUSINESS OR INDUSTRY St Joseph School	
11. BIRTHPLACE (State or foreign country) Lonaconing, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Elizabeth Fair	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. none	
17. INFORMANT James Fair		Address Midland, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 490 x Lobar Pneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH 6 days
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)		21. I certify that I attended the deceased from Oct 23, 1957 , to Oct 29, 1957 , that I last saw the deceased alive on Oct 28, 1957 , and that death occurred at 5:30 A.M. from the causes and on the date stated above.	
ACTUAL SIGNATURE W O Mc Lane M.D.		ADDRESS (Street, city or town, state) Frostburg DATE SIGNED Oct 30 1957	
PHYSICIAN'S NAME (Type) W O Mc Lane			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 10/31/57	22c. NAME OF CEMETERY OR CREMATORY Belvedere Cemetery	22d. LOCATION (City, town, or county) (State) Midland, Md.
23. FUNERAL DIRECTOR'S SIGNATURE George Eichhorn ADDRESS Lonaconing, Md.		24a. REC'D BY REGISTRAR 10-31-57 24b. REGISTRAR'S SIGNATURE W. H. H. R. R.	

MEDICAL CERTIFICATION

CENTRICAL DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 10

BUREAU V. S.

RECEIVED

NOV 5 1952

Name		Age		Sex		Race		Religion		Marital Status		Occupation		Education		Date of Birth		Date of Death		Cause of Death		Place of Death		Time of Death		Signature		Date	

10134

CERTIFICATE OF DEATH

Reg. Dist. No. 10

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Savage				c. LENGTH OF STAY IN 1b Lifetime			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) xo Mt. Savage			
				d. STREET ADDRESS Calla Hill		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Thomas Middle J. Last Farrell				4. DATE OF DEATH Month Oct. Day 20th Year 19 57			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 17th, 1874	
				9. AGE (In years last birthday) 83 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Carpenter				10b. KIND OF BUSINESS OR INDUSTRY C.&P.R.R.		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Patrick Farrell				14. MOTHER'S MAIDEN NAME Catherine Garrity			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. None		17. INFORMANT Address Miss Helen Farrell, Greenwich, Conn.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) METASTATIC CARCINOMA OF TONSIL 145X DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							INTERVAL BETWEEN ONSET AND DEATH 11 hrs.
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) _____ (County) _____ (State) _____			
21. I certify that I attended the deceased from AUG 30 , 19 57 , to OCT 20 , 19 57 , that I last saw the deceased alive on OCT 21 , 19 57 , and that death occurred at 9:40 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____							
ACTUAL SIGNATURE Martin M. Rothstein M.D. M.D. 48 Broadway							
PHYSICIAN'S NAME (Type) MARTIN M. ROTHSTEIN M.D. FROSTBURG - MD.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10-23-57		22c. NAME OF CEMETERY OR CREMATORY St. Patrick's Cemetery		22d. LOCATION (City, town, or county) (State) Mt. Savage, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Joseph R. Durst, Frostburg, Md.				24a. REC'D BY REGISTRAR DATE		24b. REGISTRAR'S SIGNATURE Vernice McDermitt	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18

Page D.H. No.

BUREAU V. 8

OCT 29 1957

RECEIVED

10066

CERTIFICATE OF DEATH

Reg. Dist. No.

4

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland				c. LENGTH OF STAY IN IB 11/3/53			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Allegany County Infirmary				d. STREET ADDRESS 118 Oak Street			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) John W. Fleegle		First Middle Last		4. DATE OF DEATH October 7, 1957		Month Day Year	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 8/5/1874	9. AGE (In years birthday) yrs. 83	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired - Railroader - R. R.				10b. KIND OF BUSINESS OR INDUSTRY Schellsburg, (Bedford Pennsylvania) (County)		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Isaac S. Fleegle				14. MOTHER'S MAIDEN NAME Annie Daugherty			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO.		17. INFORMANT P.O. Box 599		Address Cumberland, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Hypostasis 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Chronic Myocarditis DUE TO (c) General arteriosclerosis				INTERVAL BETWEEN ONSET AND DEATH 24 hrs.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Senile Deterioration							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 11/3/53 , 19, to 10/7/57 , 19, that I last saw the deceased alive on 10/7/57 , 19, and that death occurred at 2:20 P. M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 49 Greene St. Cumberland, Md. DATE SIGNED 10/7/57							
ACTUAL SIGNATURE J. E. McLean M.D.				DATE SIGNED 10/7/57			
PHYSICIAN'S NAME (Type) Dr. J. E. McLean				Cumberland, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10-10-57		22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		22d. LOCATION (City, town, or county) (State) Cumberland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli				ADDRESS Cumberland, Md.		24a. REC'D BY REGISTRAR Oct 8, 1957	
				24b. REGISTRAR'S SIGNATURE W. Ross Cameron, M.D.		Acting Registrar	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 74 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, the pages should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10

CERTIFICATE OF DEATH

Name of Deceased		Date of Death	
John W. Stasie		11/3/53	
Place of Birth		Place of Death	
Stasie, John W.		Allegany County Infirmary	
Age		Cause of Death	
8/5/1871		Heart Disease	
Sex		Occupation	
Male		Retired - Railroader - R. R.	
Race		Manner of Death	
White		Natural	
Marital Status		Burial Place	
Married		Stasie, John W.	
Spouse's Name		Date of Burial	
Stasie, Annie M.		11/3/53	
Burial Place		Remarks	
Stasie, John W.			

RECEIVED
BUREAU V. S.
 OCT 10 1957

10067

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland, Md.			c. LENGTH OF STAY IN 1b 50yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland, Md. 02			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Sacred Heart Hospital				d. STREET ADDRESS 502 Montreal Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Karl Erhard Flettermann First Middle Last				4. DATE OF DEATH Month 10 Day 14 Year 1957				
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 2, 1892		
9. AGE (In years last birthday) 65 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Hostler			10b. KIND OF BUSINESS OR INDUSTRY Railroad		11. BIRTHPLACE (State or foreign country) St. Mary's, Pa.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Jerry Flettermann				14. MOTHER'S MAIDEN NAME Kate Volk				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 705-09-9933		17. INFORMANT Mrs. Karl E. Flettermann, Cumberland Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Essential Hypertension DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH 24 hrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 260X Diabetes Mellitus							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 8-11-1953 to 10-14-1957 , that I last saw the deceased alive on 10-14-1957 , and that death occurred at 11:30 P. M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Cumberland Md. DATE SIGNED 10-16-57 ACTUAL SIGNATURE W. F. Williams M.D. PHYSICIAN'S NAME (Type) W. F. Williams, M.D.								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10-17-57		22c. NAME OF CEMETERY OR CREMATORY St. Mary's Cemetery		22d. LOCATION (City, town, or county) (State) Cumberland, Md.		
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli, Cumberland, Md. ADDRESS				24a. REC'D BY REGISTRAR DATE Oct. 17, 1957		24b. REGISTRAR'S SIGNATURE W. H. Cameron		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10073

DR. LEWIS 10068 CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. LENGTH OF STAY IN 1b 2 DAYS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First CLARA Middle Clara Last FLICKINGER				4. DATE OF DEATH Month OCTOBER Day 14 Year 1957			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH JULY 18 1877	
9. AGE (In years last birthday) 80 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Own home		11. BIRTHPLACE (State or foreign country) Cumberland, Md.	
12. CITIZEN OF WHAT COUNTRY? U. S.							
13. FATHER'S NAME RICE, JOHN				14. MOTHER'S MAIDEN NAME BRANT, CATHERINE Mary			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs. William Davies Address 125 W. 3rd St., Cumberland Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bile Peritonitis 540.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Perforated stomach ulcer DUE TO (c) two days							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerotic cardio-vascular disease							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from Oct 12, 1957 , to Oct 14, 1957 that I last saw the deceased alive on Oct 13, 1957 , and that death occurred at 1:00A. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 5 Washington St., Cumberland, Md. DATE SIGNED 10/14/57							
ACTUAL SIGNATURE Thomas F. Lewis M.D.							
PHYSICIAN'S NAME (Type) DR. THOMAS LEWIS				Cumberland, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/16/57		22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		22d. LOCATION (City, town, or county) (State) Cumberland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Charles L. George ADDRESS Cumberland, Md.				24a. REC'D BY REGISTRAR Oct 15, 1957		24b. REGISTRAR'S SIGNATURE W. Ross Cameron M.D. Acting Registrar	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

DR. LEWIS

ALLEGANY

WESTVALE

WESTVALE

QUINCY

5 P.M.

QUINCY

ST. JOSEPH HOSPITAL

1957, 1958, 1959

CLARA

CLARA

CLARA

WHITE

WHITE

JOHN

JOHN

BUREAU V. B.

OCT 17 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10074

10113

CERTIFICATE OF DEATH

Reg. Dist. No.

9

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frestburg		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lonaconing, Rural (Knapps Meadow) X2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Miners Hospital		d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First NILE Middle LEANDER Last FOYE		4. DATE OF DEATH Month 10/23/1957 Day 19 Year 19	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 29th. 1898 59 yrs.
9. AGE (In years lost birthday)		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Self Employed Auto		10b. KIND OF BUSINESS OR INDUSTRY Mechanic	
11. BIRTHPLACE (State or foreign country) Wheeling, W VA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Leander Foye		14. MOTHER'S MAIDEN NAME Mary Ann Bradley	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NONE		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT Mrs. Jean Foye, Lonaconing, MD		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c):] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Cardiac Dilatation (WIFE) 434.2 DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) Asthma DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 2 Days 3 Days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Oct 21, 1957 to Oct 23, 1957 , that I last saw the deceased alive on Oct 22, 1957 , and that death occurred at 4:20 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE Womc Lane M.D. Frestburg Oct 23, 1957 PHYSICIAN'S NAME (Type) Womc Lane MD md			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/26/1957	
22c. NAME OF CEMETERY OR CREMATORY Laurel Hill Cemetery.		22d. LOCATION (City, town, or county) (State) Moscow, MD.	
23. FUNERAL DIRECTOR'S SIGNATURE GEORGE EICHHORN		ADDRESS LONA CONING, MD.	
24a. REC'D BY REGISTRAR DATE 10-26-57		24b. REGISTRAR'S SIGNATURE Mrs. Harry R. Rose	

10069

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 Cumberland	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Allegany County Infirmary		d. STREET ADDRESS 1 746 Maryland Avenue	
3. NAME OF DECEASED (Type or print) First Anna Middle M. Last Gerdeman		4. DATE OF DEATH Month October Day 24 Year 1957	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/23/1880
9. AGE (In years last birthday) 77 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Cumberland, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Christopher Nutt		14. MOTHER'S MAIDEN NAME Bernadine Rueve	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT P.O. Box 599		Address Cumberland, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Edema 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic Myocarditis (c) General Atherosclerosis		INTERVAL BETWEEN ONSET AND DEATH 36 hrs ? ?	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Valvular Heart Disease		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 5/29/57 , 19____, to 10/23/57 , 19____, that I last saw the deceased alive on 10/23/57 , 19____, and that death occurred at 11:30 A. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 49 Greene St. DATE SIGNED 10/24/57			
ACTUAL SIGNATURE James F. McLean M.D.		DATE SIGNED 10/24/57	
PHYSICIAN'S NAME (Type) Dr. J. E. McLean		Cumberland, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 10-28-57	22c. NAME OF CEMETERY OR CREMATORY St. Peter & Paul Cem.	22d. LOCATION (City, town, or county) (State) Cumberland, Md.
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli		ADDRESS Cumberland, Md.	
24a. REC'D BY REGISTRAR Oct 26, 1957		24b. REGISTRAR'S SIGNATURE W. Ross Cameron M.D. Acting Registrar	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 could be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12
 CERTIFICATE OF DEATH

Allegany		Allegany	
Cumberland		Cumberland	
Allegany County Infirmary		Allegany County Infirmary	
M. Gordon		M. Gordon	
October 21, 1957		October 21, 1957	
Cumberland, Maryland		Cumberland, Maryland	
U. S. M.		U. S. M.	
Christopher Huff		Christopher Huff	
P.O. Box 299		P.O. Box 299	
Allegany County Infirmary		Allegany County Infirmary	

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OCT 29 1957

RECEIVED

Cumberland, Md.

Dr. J. E. Holman

10070

CERTIFICATE OF DEATH

Reg. Dist. No.

4

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland, Md.			c. LENGTH OF STAY IN 1b Lifetime		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 Cumberland, Md		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 37 Oak St.				d. STREET ADDRESS 37 Oak St		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Thomas		First Thomas		Middle Wilson		Last Gray	
5. SEX M		6. COLOR OR RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 7, 1893	
9. AGE (In years last birthday) 64 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carmen		11. BIRTHPLACE (State or foreign country) Cumberland, Md.	
10b. KIND OF BUSINESS OR INDUSTRY Railroad		12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Thomas W. Gray		14. MOTHER'S MAIDEN NAME Catherine Rager	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 705-05-7732		17. INFORMANT Cleona Gray Cumberland, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Carcinoma of Pancreas 157X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH 5 months
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) NO
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from June , 19 57 , to Oct , 19 57 , that I last saw the deceased alive on 10/25 , 19 57 , and that death occurred at 11:30 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Cumberland, Md. DATE SIGNED 11/1/57							
ACTUAL SIGNATURE G. Overton Himmelwright				M.D. Cumberland, Md.			
PHYSICIAN'S NAME (Type) G. Overton Himmelwright							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-3-57		22c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park		22d. LOCATION (City, town, or county) (State) Cumberland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli				ADDRESS Cumberland, Md		24a. REC'D BY REGISTRAR Nov 4, 1957	
				24b. REGISTRAR'S SIGNATURE W. Ross Cameron, M.D.		Acting Registrar	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 16

DATE OF DEATH

DECEASED

PLACE OF DEATH

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Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10071

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10078

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Allegany</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>		c. LENGTH OF STAY IN 1b <u>7 hrs.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Memorial Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>Gray</u> Last <u>Gray</u>		4. DATE OF DEATH Month <u>Oct.</u> Day <u>17</u> Year <u>19 57</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 30-1893</u>
9. AGE (In years last birthday) <u>64</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Red Coal Miner</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Mining Coal</u>	
11. BIRTHPLACE (State or foreign country) <u>Moscow, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Frank Gray</u>		14. MOTHER'S MAIDEN NAME <u>Agnes Douglas</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>Memorial Hospital records</u>	
17. INFORMANT <u>Memorial Hospital records</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac failure</u> <u>422.2</u> DUE TO (b) <u>Ruptured left auricle of heart.</u> Conditions, if any, which gave rise to the immediate cause (a), stating the underlying cause lost. (c) <u>Pulmonary edema (marked)</u>		INTERVAL BETWEEN ONSET AND DEATH <u>7 hrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a. m. <u>19</u> p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>H.V. Deming M.D.</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED	
EXAMINER'S NAME (Type) <u>H.V. Deming M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>Oct. 18-1957</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Oct. 20, 1957</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Old Lonaconing Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Lonaconing, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>George Eichhorn, Lonaconing, Maryland.</u>		24a. REC'D BY REGISTRAR <u>Oct. 19, 1957</u>	
		24b. REGISTRAR'S SIGNATURE <u>W. Ross Cameron M.D. Acting Registrar</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the General Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

OCT 22 1967

BUREAU V. 3

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 15

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

CERTIFICATE OF DEATH

10079
Reg. Dist. No.

10114

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Garrett	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lonaconing "Rural" 11 X 1.2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Miners Hospital		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First Lily Middle Belle Last Green		4. DATE OF DEATH Month October Day 25 Year 19 57	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH December 31, 1910 46 yrs.
9. AGE (In years last birthday)		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work		10b. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (State or foreign country) Piedmont W. Va.
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Albertus Virts	
14. MOTHER'S MAIDEN NAME Blanch Bill		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. none		17. INFORMANT Stanley Green Address Lonaconing, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Adrenal Failure 481 X DUE TO Pulmonary Infarct Rt lower lobe Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Influenza (probable) (c) 24 hrs 2 48 hrs		INTERVAL BETWEEN ONSET AND DEATH 24 hrs 48 hrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Rheumatoid arthritis - Intermittent Prednisone Therapy		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 10/24 , 19 57 , to 10/25 , 19 57 , that I last saw the deceased alive on 10/25 , 19 57 , and that death occurred at 1:35 M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Hilda Jane Walters		ADDRESS (Street, city or town, state) 48 Broadway, Frostburg, Md. DATE SIGNED 10/28/57	
PHYSICIAN'S NAME (Type) Hilda Jane Walters, M. D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 10/28/57	22c. NAME OF CEMETERY OR CREMATORY Greens Cemetery	22d. LOCATION (City, town, or county) (State) Garrett County, Md.
23. FUNERAL DIRECTOR'S SIGNATURE George Eichhorn ADDRESS Lonaconing, Md.		24a. REC'D BY REGISTRAR DATE 10-28-57	24b. REGISTRAR'S SIGNATURE Mrs. Nancy H. Poe

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CERTIFICATE OF DEATH

10080

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Eckhart		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) x2 Eckhart	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS 1	
3. NAME OF DECEASED (Type or print) First JOSEPH Middle P. Last GROTER		4. DATE OF DEATH Month Oct. Day 15, Year 19 57	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-6-1882
9. AGE (In years last birthday) 75 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired motorman		10b. KIND OF BUSINESS OR INDUSTRY coal mines	
11. BIRTHPLACE (State or foreign country) Belgium		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Joseph Groter		14. MOTHER'S MAIDEN NAME Anna Holtschneider	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 214-01-6642	
17. INFORMANT John Groter, Eckhart, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) arterio sclerosis 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 2 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1955 , 19 Oct 15 , 19 57 , that I last saw the deceased alive on Sept 4 , 19 57 , and that death occurred at 5:30 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) E. Main St., Frostburg, Md. DATE SIGNED Oct 16/1957			
ACTUAL SIGNATURE W. O. McLane M.D.		PHYSICIAN'S NAME (Type) W. O. McLane, M. D.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10-17-57	
22c. NAME OF CEMETERY OR CREMATORY St. Michael's Cemetery		22d. LOCATION (City, town, or county) (State) Frostburg, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE J. R. Durst,		ADDRESS Frostburg, Md.	
24a. REC'D BY REGISTRAR DATE 10-17-57		24b. REGISTRAR'S SIGNATURE Miss Nancy H. Rea	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

OCT 23 1957

RECEIVED

1-2
Within corporate limits

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10081

10072

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

4

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Allegany		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 7 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 22 Frostburg	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Memorial Hospital			d. STREET ADDRESS 154 N.Center St		
3. NAME OF DECEASED (Type or print) First Agnes Middle Hannon Last			4. DATE OF DEATH Month Oct. Day 6 Year 19 57		
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec.1-1884		9. AGE (In years last birthday) 72 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired School teacher		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Barton,Md.	
13. FATHER'S NAME John M.J.Hannon			14. MOTHER'S MAIDEN NAME Mary Ann Martin		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO.		17. INFORMANT Address Memorial Hospital records	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary occlusion with myocardial infarction- 6 hrs 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 100.0 (b) Arteriosclerotic heart disease DUE TO (c) Generalized arteriosclerosis					INTERVAL BETWEEN ONSET AND DEATH 6 hrs ? ?
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Subdural hematoma, left, due to a fall, Operation John H.H.					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Walking toward bathroom, took wrong direction & fell down stairs.			
20c. TIME OF INJURY Month, Day, Year 1 Hour a. m. 2:27 20 1957	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Frostburg Allegany Md.	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE A. V. Deming M.D.		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) H.V. Deming M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Oct. 7-1957	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 10-8-57	22c. NAME OF CEMETERY OR CREMATORY St. Michael's		22d. LOCATION (City, town, or county) (State) Frostburg Md.	
23. FUNERAL DIRECTOR'S SIGNATURE J.R. Durst		ADDRESS Frostburg, Md.		24a. REC'D BY REGISTRAR Oct. 9, 1957	
				24b. REGISTRAR'S SIGNATURE W. Ross Cameron M.D. Acting Registrar	

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RECEIVED

OCT 10 1957

BUREAU V. 3.

DR. LEY

10073

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. LENGTH OF STAY IN 1b 12 DAYS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL				d. STREET ADDRESS 17 E. MAIN ST.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last MARABEL HARAN				4. DATE OF DEATH Month Day Year OCTOBER 30 19 57			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3/2, 1905	
9. AGE (In years last birthday) 52 23 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SCHOOL TEACHER				10b. KIND OF BUSINESS OR INDUSTRY Public School		11. BIRTHPLACE (State or foreign country) LONA CONING, MARYLAND	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME WILLIAM FISHER				14. MOTHER'S MAIDEN NAME MARRIETT CONNOR			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Memorial Hospital		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Cardiac Failure 410X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Mitral Stenosis DUE TO (c) Rheumatic Fever PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 10/19 , 19 57 , to 10/30 , 19 57 , that I last saw the deceased alive on 10/29 , 19 57 , and that death occurred at 6:10 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Leo N. Ley Jr.				ADDRESS (Street, city or town, state) 456 N. Centre St.			
DATE SIGNED 10/31/57							
PHYSICIAN'S NAME (Type) DR. LEO LEY				Cumberland Ind.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov. 2, 1957		22c. NAME OF CEMETERY OR CREMATORY Frostburg Memorial Park		22d. LOCATION (City, town, or county) (State) Frostburg, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE George Eichhorn, Lonaconing, Maryland.				24a. REC'D BY REGISTRAR Nov 1, 1957		24b. REGISTRAR'S SIGNATURE W. Ross Cameron M.D. <i>Acting Registrar</i>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. 3.

NOV 7 1957

RECEIVED

10136

CERTIFICATE OF DEATH

10083

Reg. Dist. No. 6

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural-Westernport				c. LENGTH OF STAY IN 1b 14 Yrs			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) x2 Rural-Westernport							
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Stoney Run Road				d. STREET ADDRESS Stoney Run Road			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Margaret Middle Katherine Last Harris				4. DATE OF DEATH Month Oct. Day 17 Year 1957			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec. 15, 1942	
9. AGE (In years last birthday) 14 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student				10b. KIND OF BUSINESS OR INDUSTRY High School		11. BIRTHPLACE (State or foreign country) Westernport, Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Alfred Harris				14. MOTHER'S MAIDEN NAME Opal Lambert			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no				16. SOCIAL SECURITY NO.		17. INFORMANT Alfred Harris-Westernport, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Chest 196X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma of Tibia DUE TO (c) _____				INTERVAL BETWEEN ONSET AND DEATH 3 months 7 months			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from June 1, 1957 , to Oct 17, 1957 , that I last saw the deceased alive on Oct 17, 1957 , and that death occurred at 11:00 M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Piedmont Wva DATE SIGNED ACTUAL SIGNATURE P. E. Berry M.D. PHYSICIAN'S NAME (Type) P. E. BERRY							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/20/57		22c. NAME OF CEMETERY OR CREMATORY Philos Cem.		22d. LOCATION (City, town, or county) (State) Westernport Md.	
23. FUNERAL DIRECTOR'S SIGNATURE El. Bwal				ADDRESS Westernport, Md.		24a. REC'D BY REGISTRAR DATE 10-21-57	
24b. REGISTRAR'S SIGNATURE Jim C Kelly							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH	
JAMES EARL RAY		35		Male		White		April 14, 1928		Jackson, Mississippi	
MANNER OF DEATH		CAUSE OF DEATH		DISEASE OR INJURY		PERIOD OF ILLNESS		PLACE OF DEATH		DATE OF DEATH	
Suicide		Gunshot wound		Suicide		Several days		Birmingham, Alabama		April 4, 1968	
OCCUPATION		EDUCATION		RELIGION		MARITAL STATUS		SINGLE		DATE OF MARRIAGE	
Attorney		High School		Methodist		Single					
FAMILY HISTORY		PREVIOUS ILLNESS		PREVIOUS SURGERY		PREVIOUS TRAUMA		PREVIOUS DRUGS		PREVIOUS ALCOHOL	
None		None		None		None		None		None	
MEDICAL HISTORY		PREVIOUS DEATHS		PREVIOUS INFANTS		PREVIOUS CHILDREN		PREVIOUS SIBLINGS		PREVIOUS PARENTS	
None		None		None		None		None		None	
FAMILY HISTORY		PREVIOUS DEATHS		PREVIOUS INFANTS		PREVIOUS CHILDREN		PREVIOUS SIBLINGS		PREVIOUS PARENTS	
None		None		None		None		None		None	

BUREAU V. 2

OCT 29 1967

RECEIVED

RECEIVED

OCT 22 1957

BUREAU V. 3

STATE OF MARYLAND
DEPARTMENT OF HEALTH
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME: [illegible]
AGE: [illegible]
SEX: [illegible]
RACE: [illegible]
DATE OF BIRTH: [illegible]
PLACE OF BIRTH: [illegible]
DATE OF DEATH: [illegible]
PLACE OF DEATH: [illegible]
CAUSE OF DEATH: [illegible]
MANNER OF DEATH: [illegible]
SIGNATURE OF EXAMINER: [illegible]
DATE: [illegible]

10137

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Cumberland		c. LENGTH OF STAY IN 1b 6 mos	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 Cumberland			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Rt. 3, Bedford Road		d. STREET ADDRESS 811 Columbia Avenue	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Elizabeth Agnes Hast		4. DATE OF DEATH October 30, 1957 19	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 30, 1870
9. AGE (In years last birthday) 87 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Cumberland, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Henry Anthony Gerdeman		14. MOTHER'S MAIDEN NAME Elizabeth Schellhaus	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs. Ambrose Burkey, Rt. 3, Bedford Road, Cumberland, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerosis + Calcification DUE TO (c) Interval between onset and death 6 mos			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 76 Oct 57 19 to 30 Oct 57 19, that I last saw the deceased alive on 26 Oct 57 19, and that death occurred at 2:15 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE David Thomas Rees M.D.		ADDRESS (Street, city or town, state) 705 West Jones Ave, Cumberland, Md	
PHYSICIAN'S NAME (Type) David Thomas Rees, M.D.		DATE SIGNED 11/2/57	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov. 2, 1957	
22c. NAME OF CEMETERY OR CREMATORY Sts. Peter & Pauls Cem.		22d. LOCATION (City, town, or county) (State) Cumberland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer, Cumberland, Maryland		24a. REC'D BY REGISTRAR DATE 2, 1957	
		24b. REGISTRAR'S SIGNATURE W. Ross Cameron, M.D. Acting Registrar	

BUREAU V. S.

NOV 2 1951

RECEIVED

1
Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10086

DR. HIMMELWRIGHT

1007 CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE WEST VIRGINIA b. COUNTY MINERAL	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WILEY FORD 85X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First ANNA Middle F. Last HEPNER		4. DATE OF DEATH Month OCTOBER Day 6 Year 19 57	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH DECEMBER 24, 1876
9. AGE (In years last birthday) 80 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME	
11. BIRTHPLACE (State or foreign country) VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME HARVEY WISDOM STUSING		14. MOTHER'S MAIDEN NAME GATHERINE SAGER	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT MEMORIAL HOSPITAL - CUMBERLAND, MD.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Carcinoma to Lung and Pleura DUE TO Etiology undetermined. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept , 19 57 , to Oct , 19 57 , that I last saw the deceased alive on Oct 5 , 19 57 , and that death occurred at 6:10 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, State) 133 Virginia Ave, Cumberland DATE SIGNED 10/7/57 ACTUAL SIGNATURE Dr. Himmelwright M.D. W. Ross Cameron, M.D. PHYSICIAN'S NAME (Type) DR. O. HIMMELWRIGHT			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Oct. 9, 1957	22c. NAME OF CEMETERY OR CREMATORY Forest Glen Cemetery	22d. LOCATION (City, town, or county) (State) Greenspring, West Virginia
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli, Cumberland, Maryland.		24a. REC'D BY REGISTRAR Oct 9, 1957 24b. REGISTRAR'S SIGNATURE W. Ross Cameron, M.D. Acting Registrar	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

Within corporate limits

10076

CERTIFICATE OF DEATH

Reg. Dist. No.

4

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. LENGTH OF STAY IN 1b 60AYS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL				d. STREET ADDRESS 758 MARYLAND AVE			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last CECELIA HEWETT				4. DATE OF DEATH Month Day Year OCTOBER 31 19 57			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH JAN. 24, 1884	
9. AGE (In years last birthday) yrs. 73		IF UNDER 1 YEAR Months Days Hours Min. 73		IF UNDER 24 HRS. 73			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Own home		11. BIRTHPLACE (State or foreign country) Bedford Co., Penna.	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME WIGFIELD, Alexander				14. MOTHER'S MAIDEN NAME POTTS, Mary Jane			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No,				16. SOCIAL SECURITY NO. None		17. INFORMANT Address MEMORIAL HOSPITAL CUMBERLAND, MD	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Left Ventricular Failure 420.1 DUE TO (b) Acute myocardial infarction (Pulmonary edema) Conditions, if any, which gave rise to immediate case (a), stating the underlying cause lost. (c) Coronary Thrombosis DUE TO (b) 6 days DUE TO (c) 6 days PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 490x PNEUMONIA, LOBAR INTERVAL BETWEEN ONSET AND DEATH 2 days 6 days 6 days							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from Oct 25, 1957 , to October 31, 1957 , that I last saw the deceased alive on October 31, 1957 , and that death occurred at 7:25 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 596 GREENE ST Nov 1 1957 ACTUAL SIGNATURE Dr. S. G. Weisman M.D. PHYSICIAN'S NAME (Type) DR. S. G. WEISMAN CUMBERLAND, MD							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 11/3/57		22c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park	
22d. LOCATION (City, town, or county) (State) Cumberland, Maryland							
23. FUNERAL DIRECTOR'S SIGNATURE H. Wayne George				ADDRESS Cumberland, Maryland		24a. REC'D BY REGISTRAR Nov 2 1957	
24b. REGISTRAR'S SIGNATURE W. Ross Cameron, M.D.				Acting Registrar			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH	
JAMES M. WHITE		Male		45		1880		BALTIMORE, MD.	
RESIDENCE		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		PLACE OF DEATH	
1234 BALTIMORE AVE.		Clerk		Heart Disease		Natural		Home	
DATE OF DEATH		TIME OF DEATH		HOUR OF DEATH		MINUTE OF DEATH		SECOND OF DEATH	
Nov 10 1957		10:30 AM		10		30		00	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	

BUREAU V. S.
NOV 6 1957
RECEIVED

10077

CERTIFICATE OF DEATH

10088

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>			
c. LENGTH OF STAY IN 1b <u>Life</u>				d. STREET ADDRESS <u>601 Washington St.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Crompton Nursing Home.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Florence</u> Middle <u>Hill</u> Last <u>Hill</u>				4. DATE OF DEATH Month <u>Oct</u> Day <u>3</u> Year <u>1957</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>March 8, 1880</u>	
9. AGE (In years last birthday) <u>77</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>Cumberland Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Scott Reid</u>				14. MOTHER'S MAIDEN NAME <u>Dessie Fuller</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>Mrs Robt. Fitzsimmons Balto Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic Myocarditis</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerosis, Generalized</u> DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH <u>5 yrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan</u> , 19 <u>55</u> , to <u>Sept 30</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Sept 30</u> , 19 <u>57</u> , and that death occurred at <u>11:15 P</u> .M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>R. W. Trevaski, Jr.</u> M.D.				ADDRESS (Street, city or town, state) <u>Cumberland</u>			
DATE SIGNED _____							
22a. DATE OF BURIAL, CREMATION, OR REMOVAL (Specify) <u>10/5/57</u>		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY <u>Frostburg Memo. Park</u>		22d. LOCATION (City, town, or county) (State) <u>Frostburg Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Louis Stern Inc</u>				ADDRESS <u>Cumberland</u>		24a. REC'D BY REGISTRAR <u>W. Ross Cameron M.D.</u>	
				DATE <u>10/5/1957</u>		24b. REGISTRAR'S SIGNATURE <u>Acting Registrar</u>	

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 12

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY		COUNTY		STATE	
JAMES H. HARRIS		65		M		W		1892		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE	
MARRIAGE		DATE		PLACE		CITY		COUNTY		STATE		CITY		COUNTY		STATE	
MARRIED		1915		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE	
EDUCATION		SCHOOL		COLLEGE		UNIVERSITY		DEGREE		CITY		COUNTY		STATE		CITY	
HIGH SCHOOL		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE	
OCCUPATION		BUSINESS		MANAGER		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE	
MILITARY		ARMY		NAVY		AIR FORCE		MARINE CORPS		COAST GUARD		NATIONAL GUARD		RESERVE		CITY	
ARMY		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE	
NAVY		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE	
AIR FORCE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE	
MARINE CORPS		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE	
COAST GUARD		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE	
NATIONAL GUARD		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE	
RESERVE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE	
CITY		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE	
COUNTY		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE	
STATE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE	
CITY		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE	
COUNTY		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE	
STATE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE	
CITY		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE	
COUNTY		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE	
STATE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE	

BUREAU V. S.

OCT 8 1957

RECEIVED

1
 WITHIN corporate limits
 FOR STATE
 HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10089

10078

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

4

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Allegany</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>		c. LENGTH OF STAY IN 1b <u>14 yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>02 Cumberland</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Memorial Hospital</u>				d. STREET ADDRESS <u>639 N. Mechanic St.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>William</u> Last <u>Hoyman</u>				4. DATE OF DEATH Month <u>Oct.</u> Day <u>13</u> Year <u>19 57</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <u>June 5-1915</u>		9. AGE (In years last birthday) <u>42</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Warehouse Mgr. & Chauffeur-Carpenter Bros</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>& Son.</u>		11. BIRTHPLACE (State or foreign country) <u>Somerset Co. Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Lewis Hoyman</u>				14. MOTHER'S MAIDEN NAME <u>Edna Fisher</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>212-12-8459</u>		17. INFORMANT <u>(wife) Ivy L. Hoyman, Cumberland, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Coronary sclerosis with angina syndrome</u> (c) <u>Arteriosclerosis with hypertention</u>						INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u> <u>5 mo.</u> <u>5 mo.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour <u> </u> a. m. <u> </u> p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)		(County)		(State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>H. V. Deming M.D.</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>H. V. Deming M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>Oct. 14-1957</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Oct. 16, 1957</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Zion Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Garrett County, Maryland</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles L. George, Cumberland, Maryland.</u>				24a. REC'D BY REGISTRAR <u>Oct. 15, 1957</u>		24b. REGISTRAR'S SIGNATURE <u>W. Ross Cameron M.D.</u> <u>Acting Registrar</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

OCT 17 1967

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10115

CERTIFICATE OF DEATH

Reg. Dist. No.

10099

1. PLACE OF DEATH o. COUNTY <u>ALLEGANY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>CARRETT</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>FROSTBURG</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>GRANTSVILLE (RURAL)</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>MINERS HOSPITAL</u>				d. STREET ADDRESS <u>11X12</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>GEORGE MELVILLE Hummel</u>				4. DATE OF DEATH Month Day Year <u>OCT. 12 1957</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>OCT. 4, 1887</u>	9. AGE (In years last birthday) <u>70</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FARM</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Samuel Daniel D. Hummel</u>				14. MOTHER'S MAIDEN NAME <u>MARY TATE</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>W W I</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>HOSPITAL RECORDS</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Coronary Atherosclerosis</u> DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH <u>1 DAY</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)		(County)	(State)	
21. I certify that I attended the deceased from <u>OCT 11, 1957</u> , to <u>OCT 12, 1957</u> , that I last saw the deceased alive on <u>OCT 12, 1957</u> , and that death occurred at <u>3</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>John C. Devers</u>				ADDRESS (Street, city or town, state) <u>134 E. Main</u>		DATE SIGNED <u>10/18/57</u>	
PHYSICIAN'S NAME (Type) <u>John C. Devers</u>				<u>FROSTBURG, MD</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>OCT. 15, 1957</u>	22c. NAME OF CEMETERY OR CREMATORY <u>TRINITY REFORMED</u>		22d. LOCATION (City, town, or county) <u>GRANTSVILLE MD</u>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Donald J. Deuman</u>				ADDRESS <u>Grantsville, Md.</u>		24a. REC'D BY REGISTRAR <u>10-14-57</u>	24b. REGISTRAR'S SIGNATURE <u>Miss Nancy H. Poe</u>

CERTIFICATE OF DEATH

Form with multiple sections for recording death information, including fields for name, date, cause, and location. The form is partially filled with handwritten text.

NAME OF DECEASED: *James M. Smith*

DATE OF DEATH: *Oct 12 1957*

PLACE OF DEATH: *Home*

CAUSE OF DEATH: *Heart Disease*

LOCATION OF DEATH: *Baltimore, Md.*

Signature: *[Handwritten Signature]*

OCT 17 1957

RECEIVED

BUREAU Y. S.

DR. DURRETT

10079

CERTIFICATE OF DEATH

10091
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL		d. STREET ADDRESS 125 ELDER STREET	
3. NAME OF DECEASED (Type or print) First EDNA Middle G. Last ISER		4. DATE OF DEATH Month OCTOBER Day 19 Year 1957	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH SEPTEMBER 13, 1895
9. AGE (In years last birthday) yrs. 62		10. IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) WEST VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME NELSON FADLEY		14. MOTHER'S MAIDEN NAME ANNA WOODWOR	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.	
17. INFORMANT MEMORIAL HOSPITAL - CUMBERLAND, MARYLAND		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of uterus 174X DUE TO Carcinomatous Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 23raemia (c) 6 rtk PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 1957 to Oct. 19 , 1957, that I last saw the deceased alive on Oct. 18 , 1957, and that death occurred at 2:15 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Clayton Jones M.D.		ADDRESS (Street, city or town, state) Cumberland - Md. DATE SIGNED 10/29/57	
PHYSICIAN'S NAME (Type) DR. C. DURRETT			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Oct. 22, 1957	22c. NAME OF CEMETERY OR CREMATORY Abe Cemetery	22d. LOCATION (City, town, or county) (State) Mineral County, West Virginia
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli, Cumberland, Maryland.		24a. REC'D BY REGISTRAR Oct. 21, 1957 24b. REGISTRAR'S SIGNATURE W. Ross Cameron M.D. Acting Registrar	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

OCT 22 1957

RECEIVED

10080

CERTIFICATE OF DEATH

10092

Reg. Dist. No. 4

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 Cumberland			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Sacred Heart Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Edward Middle E. Last Killander				4. DATE OF DEATH Month 10/25 Day 1957			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8/11/78	
9. AGE (In years lost birthday) 79 yrs.		IF UNDER 1 YEAR Months 79 Days 79 Hours 79 Min. 79		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sweeper		10b. KIND OF BUSINESS OR INDUSTRY Chinese Corp of Am.	
11. BIRTHPLACE (State or foreign country) Sweden		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Victor Killander		14. MOTHER'S MAIDEN NAME Sophia (Unknown)	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 214-67-4532		17. INFORMANT Patient's chart		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute lymphocytic leukemia 2040 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from 10/22 , 19 57 , to 10/25 , 19 57 , that I last saw the deceased alive on 10/24 , 19 57 , and that death occurred at 7:54 A.M., from the causes and on the date stated above.							
ACTUAL SIGNATURE Leo H. Ley, Jr.				DATE SIGNED 10/25/57			
PHYSICIAN'S NAME (Type) Leo H. Ley, Jr., M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Buried		22b. DATE THEREOF 10/28/57		22c. NAME OF CEMETERY OR CREMATORY St. Peter & Paul Cem.		22d. LOCATION (City, town, or county) (State) Cum. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Louis Stein Inc.				24a. REC'D BY REGISTRAR W. Ross Cameron, M.D.		24b. REGISTRAR'S SIGNATURE Acting Registrar	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 6 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 19

Age at Death

DATE OF DEATH

PLACE

IN CASE OF DEATH BY SUICIDE, THE DECEASED MUST BE REPORTED TO THE ATTORNEY GENERAL'S OFFICE, BALTIMORE, MARYLAND, BY THE PERSON OR PERSONS NAMED IN THIS CERTIFICATE.

DECEASED'S NAME

DATE OF BIRTH

DECEASED'S SEX

DECEASED'S RACE

DECEASED'S SEX

DECEASED'S RACE

DECEASED'S OCCUPATION, TRADE, BUSINESS, OR PROFESSION

DECEASED'S MARITAL STATUS

DECEASED'S PLACE OF BIRTH

DECEASED'S PLACE OF DEATH

DECEASED'S PLACE OF INTERMENT

DECEASED'S PLACE OF RESIDENCE

DECEASED'S PLACE OF DEATH

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BUREAU V. 2

OCT 29 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10116

CERTIFICATE OF DEATH

10093

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg				c. LENGTH OF STAY IN 1b 9 yrs			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Minor's Hospital				d. STREET ADDRESS 90 1/2 Braddock Road			
3. NAME OF DECEASED (Type or print) First Joseph Middle Anthony Last Kohout Jr.				4. DATE OF DEATH Month 10 Day 26 Year 1957			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug. 1st. 1908	
9. AGE (In years last birthday) 49 yrs.		IF UNDER 1 YEAR Months 10 Days 26 Hours 19 Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Instructor		10b. KIND OF BUSINESS OR INDUSTRY College	
11. BIRTHPLACE (State or foreign country) Erie, Pa.				12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME Joseph A. Kohout, Sr.				14. MOTHER'S MAIDEN NAME Matilda M. Motycka			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) World War II 409-16-1612		17. INFORMANT 90 1/2 Braddock Road, Frostburg, Md. Mrs. Jos. A. Kohout, Jr. Wife			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Acute Myocardial Infarction Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary Artery Thrombosis (c) hours PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) weeks							INTERVAL BETWEEN ONSET AND DEATH hours weeks
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from OCT 20, 1957 , to OCT 26, 1957 , that I last saw the deceased alive on OCT 26, 1957 , and that death occurred at 10 P. M. from the causes and on the date stated above.							
ACTUAL SIGNATURE John C. Devcas M.D.				ADDRESS (Street, city or town, state) 134 E. Main DATE SIGNED 10/28/57			
PHYSICIAN'S NAME (Type) John C. Devcas				Frostburg, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 10-28-1957		22c. NAME OF CEMETERY OR CREMATORY Buttram Cemetery		22d. LOCATION (City, town, or county) (State) Dayton Tenn.	
23. FUNERAL DIRECTOR'S SIGNATURE Charles H. Mattingly				24a. REC'D BY REGISTRAR DATE 10-28-57		24b. REGISTRAR'S SIGNATURE Mrs. Nancy H. Rose	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

BUREAU V. S.

NOV 5 1957

RECEIVED

Item 20 Film 221 10-25-57 ams

CERTIFICATE OF DEATH

10094
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg		c. LENGTH OF STAY IN 1b 2 wks.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Miners Hospital		e. STREET ADDRESS 16 Green St.	
3. NAME OF DECEASED (Type or print) First CHARLOTTE Middle (KIRBY) Last KRAUSE		4. DATE OF DEATH Month October Day 13 Year 19 57	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-9-1878
9. AGE (In years lost birthday) 78 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired janitoress		10b. KIND OF BUSINESS OR INDUSTRY Post Office	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Thomas Kirby		14. MOTHER'S MAIDEN NAME Sarah Jane Koontz	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) none		17. INFORMANT Address Mrs. Eleanor Fram, Frostburg, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ① Toxic Uremia 9/16.0 DUE TO ③ 2nd 3rd degree burns R arm + Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. triggers DUE TO (c) Malnutrition + Hypoproteinemia			INTERVAL BETWEEN ONSET AND DEATH 48 hrs. 3 weeks
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ② Malnutrition + Hypoproteinemia			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) lit gas stove oven after gas had been on a few moments, lighted gas whooshed out on R hand and arm	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Kitchen		20f. (City or town) (County) (State) Frostburg Allegany Md.	
21. I certify that I attended the deceased from 9/28 , 19 57 , to 10/13 , 19 57 , that I last saw the deceased alive on 10/13 , 19 57 , and that death occurred at 8:25 A.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE Frank T. Harrat M.D.		ADDRESS (Street, city or town, state) 26 W. Mechanic St.,	
PHYSICIAN'S NAME (Type) F. T. Harrat, M. D.		DATE SIGNED Frostburg, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 10-16-57	22c. NAME OF CEMETERY OR CREMATORY Zion Evan. & Ref. Cemetery	
22d. LOCATION (City, town, or county) (State) Frostburg, Md.			
23. FUNERAL DIRECTOR'S SIGNATURE J. R. Durst, Frostburg, Md.		24a. REC'D BY REGISTRAR DATE 10-15-57	
		24b. REGISTRAR'S SIGNATURE Mrs. Nancy N. Rie	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

1. NAME OF DECEASED <i>JOHN J. SMITH</i>		2. SEX <i>MALE</i>		3. AGE <i>45</i>		4. DATE OF BIRTH <i>1912</i>		5. PLACE OF BIRTH <i>NEW YORK</i>		6. OCCUPATION <i>CLERK</i>	
7. MARITAL STATUS <i>MARRIED</i>		8. RACE <i>WHITE</i>		9. RELIGION <i>CATHOLIC</i>		10. EDUCATION <i>HIGH SCHOOL</i>		11. SOCIAL SECURITY NUMBER <i>123-45-6789</i>		12. PLACE OF DEATH <i>HOSPITAL</i>	
13. DATE OF DEATH <i>OCT 15 1957</i>		14. TIME OF DEATH <i>10:30 AM</i>		15. CAUSE OF DEATH <i>HEART DISEASE</i>		16. MANNER OF DEATH <i>NATURAL</i>		17. SIGNATURE OF PHYSICIAN <i>DR. J. H. BROWN</i>		18. SIGNATURE OF REGISTRAR <i>JOHN J. SMITH</i>	
19. SIGNATURE OF DECEASED <i>JOHN J. SMITH</i>		20. SIGNATURE OF NEXT OF KIN <i>MRS. J. H. BROWN</i>		21. SIGNATURE OF WITNESS <i>DR. J. H. BROWN</i>		22. SIGNATURE OF WITNESS <i>DR. J. H. BROWN</i>		23. SIGNATURE OF WITNESS <i>DR. J. H. BROWN</i>		24. SIGNATURE OF WITNESS <i>DR. J. H. BROWN</i>	

BUREAU V. S.

OCT 17 1957

RECEIVED

10138

CERTIFICATE OF DEATH

10095

Reg. Dist. No. 6

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Luke				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Luke			
c. LENGTH OF STAY IN 1b 50 Yrs				d. STREET ADDRESS 313 Pratt			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 313 Pratt St.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First John Middle Andrew Last Krumpack				4. DATE OF DEATH Month Oct. Day 20 Year 1957.			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Mar. 7, 1884	
9. AGE (In years last birthday) 73 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer				10b. KIND OF BUSINESS OR INDUSTRY Paper Mill		11. BIRTHPLACE (State or foreign country) Hungary	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME John Krumpack				14. MOTHER'S MAIDEN NAME Rosala Toth			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no				16. SOCIAL SECURITY NO. 27-05-0257			
17. INFORMANT Mrs. Margaret Brandlen-Luke, Md.				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerosis and Hypertension DUE TO (c) 8 Years INTERVAL BETWEEN ONSET AND DEATH 5 Minutes							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) None				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from Mar 10, 1949 , to Oct 20, 1957 , that I last saw the deceased alive on Oct 18, 1957 , and that death occurred at 10:15 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Piedmont, W. Va. DATE SIGNED 10-21-57 ACTUAL SIGNATURE Paul R. Wilson M.D. PHYSICIAN'S NAME (Type) Paul R. Wilson M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct. 23, 1957		22c. NAME OF CEMETERY OR CREMATORY St. Peters Cem		22d. LOCATION (City, town, or county) (State) Westernport, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE E. L. Boral				ADDRESS Westernport, Md.		24a. REC'D BY REGISTRAR DATE 10-22-57	
24b. REGISTRAR'S SIGNATURE Jean C Kelly							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MAINTAIN STATE DEPARTMENT OF HEALTH - BATHING, 18

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY		STATE		COUNTRY	
JAMES EARL RAY		35		M		W		1922		MOBILE, ALABAMA		MOBILE		ALABAMA		UNITED STATES	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		DISEASE OR INJURY		PERIOD OF ILLNESS		TREATMENT		POST-MORTEM		SIGNATURE OF PHYSICIAN	
APRIL 4, 1968		MEMPHIS, TENNESSEE		SHOOTING		HOMICIDE		GUNSHOT WOUNDS		SEVERAL DAYS		HOSPITAL		NO		JAMES EARL RAY	
SIGNATURE OF DECEASED		SIGNATURE OF NEXT OF KIN		SIGNATURE OF PHYSICIAN		SIGNATURE OF CORONER		SIGNATURE OF MINISTER		SIGNATURE OF BURIAL		SIGNATURE OF INTERMENT		SIGNATURE OF FUNERAL HOME		SIGNATURE OF CEMETERY	

BUREAU V. 3

OCT 25 1957

RECEIVED

10118

CERTIFICATE OF DEATH

10096

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Miners Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First ROBERT Middle H. Last LANCASTER				4. DATE OF DEATH Month October Day 27 Year 19 57			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11-17-1929	
9. AGE (In years last birthday) 27 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman				10b. KIND OF BUSINESS OR INDUSTRY Queen City Dairy		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Hilary Lancaster				14. MOTHER'S MAIDEN NAME Nellie Lavin			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service) NO				16. SOCIAL SECURITY NO. 723-14-8195			
17. INFORMANT Mrs. Mabel Lancaster				Address Route 1, Frostburg, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 480x DUE TO Nephrosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Uremia + Secondary DUE TO Renoviria due to Flu (c) Renoviria due to Flu						INTERVAL BETWEEN ONSET AND DEATH 2 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from April, 1953 , to OCT 27, 1957 , that I last saw the deceased alive on OCT 27, 1957 , and that death occurred at 9:20 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) E. Main St., Frostburg, Md. DATE SIGNED John C. Devers							
ACTUAL SIGNATURE John C. Devers M.D.							
PHYSICIAN'S NAME (Type) John B. Devers, M. D.				Frostburg, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10-29-57		22c. NAME OF CEMETERY OR CREMATORY F'bg. Memorial Park		22d. LOCATION (City, town, or county) (State) Frostburg, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE J. R. Durst,				ADDRESS Frostburg, Md.		24a. REC'D BY REGISTRAR DATE 10-29-57	
				24b. REGISTRAR'S SIGNATURE Mrs. Nancy N. Devers			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		STATE OF BIRTH		COUNTRY OF BIRTH	
DATE OF DEATH		TIME OF DEATH		PLACE OF DEATH		CITY OF DEATH		STATE OF DEATH		COUNTRY OF DEATH		DATE OF DEATH		TIME OF DEATH		PLACE OF DEATH	
CAUSE OF DEATH		MANNER OF DEATH		DISEASE		SYMPTOMS		TREATMENT		DIAGNOSIS		HISTORY		FAMILY HISTORY		SOCIAL HISTORY	
SIGNATURE OF PHYSICIAN		SIGNATURE OF CORONER		SIGNATURE OF JURY		SIGNATURE OF WITNESSES		SIGNATURE OF DECEASED		SIGNATURE OF NEXT OF KIN		SIGNATURE OF CLERGY		SIGNATURE OF BURIAL		SIGNATURE OF CREMATION	

BUREAU V. S.

NOV 5 1957

RECEIVED

10119

CERTIFICATE OF DEATH

10097

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg				c. LENGTH OF STAY IN 1b Lifetime			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Miners Hospital				e. STREET ADDRESS 116 Ormond St.			
3. NAME OF DECEASED (Type or print) First JAMES Middle B. Last LEWIS				4. DATE OF DEATH Month Oct. Day 12, Year 19 57			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-12-1890		9. AGE (In years last birthday) 67 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired mechanic helper				10b. KIND OF BUSINESS OR INDUSTRY Celanese Corp.		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Edward Lewis				14. MOTHER'S MAIDEN NAME Mary Thomas			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 216-10-1325		17. INFORMANT Address Mrs. James Lewis, Frostburg, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertensive Cardio-vascular disease 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 4-5 years.						PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from 6-1 , 19 52 , to 10-11 , 19 57 , that I last saw the deceased alive on 10-11 , 19 57 , and that death occurred at 11:50 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) W. Main St., Frostburg, Md. DATE SIGNED 10-14-57							
ACTUAL SIGNATURE H. C. Diehl				M.D. W. Main St., Frostburg, Md.			
PHYSICIAN'S NAME (Type) H. C. Diehl, M. D.				Frostburg, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10-14-57		22c. NAME OF CEMETERY OR CREMATORY F'b'g. Memorial Park		22d. LOCATION (City, town, or county) (State) Frostburg, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE J. R. Durst				ADDRESS Frostburg, Md.		24a. REC'D BY REGISTRAR DATE 10-14-57	
				24b. REGISTRAR'S SIGNATURE Sm. Mary N. Rag			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED <i>Thelma Louise Carter</i>		2. SEX <i>Female</i>		3. AGE <i>42</i>	
4. DATE OF DEATH <i>Oct 17 1957</i>		5. TIME OF DEATH <i>10:11 AM</i>		6. PLACE OF DEATH <i>Home</i>	
7. CAUSE OF DEATH <i>Myocardial Infarction</i>		8. MANNER OF DEATH <i>Natural</i>		9. MEDICAL HISTORY <i>None</i>	
10. SIGNATURE OF PHYSICIAN <i>[Signature]</i>		11. SIGNATURE OF REGISTRAR <i>[Signature]</i>		12. SIGNATURE OF WITNESS <i>[Signature]</i>	
13. SIGNATURE OF DECEASED <i>[Signature]</i>		14. SIGNATURE OF NEXT OF KIN <i>[Signature]</i>		15. SIGNATURE OF BURIAL OFFICER <i>[Signature]</i>	

BUREAU V. B

OCT 17 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10098

10139

CERTIFICATE OF DEATH

Reg. Dist. No. 14

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Corrigansville, rural				c. LENGTH OF STAY IN 1b x2 Corrigansville, rural			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Ellerslie Rd.				d. STREET ADDRESS Ellerslie Rd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First WILLIAM Middle HENRY Last LILLER		4. DATE OF DEATH Month Oct. Day 8, Year 19 57			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 27, 1870		9. AGE (In years last birthday) yrs. 87	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Stationary Engineer Silk		10b. KIND OF BUSINESS OR INDUSTRY Silk		11. BIRTHPLACE (State or foreign country) Purgittsville, W. Va.		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Emanuel Liller				14. MOTHER'S MAIDEN NAME Ellen Bobo			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No,		16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs. Olive Workman Corrigansville, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Heart Failure 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Heart Disease DUE TO (c) Senility							INTERVAL BETWEEN ONSET AND DEATH 3 min.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Home , 19 55 , to Oct 8 , 19 57 , that I last saw the deceased alive on Sept 24 , 19 57 , and that death occurred at 9:40 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE William P. James M.D.				ADDRESS (Street, city or town, state) 441 N. Centre St.,		DATE SIGNED 10-10-57	
PHYSICIAN'S NAME (Type) William P. James M. D.				Cumberland, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/12/57		22c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park		22d. LOCATION (City, town, or county) (State) Cumberland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Charles L. George				ADDRESS Cumberland, Md.		24a. REC'D BY REGISTRAR DATE 11, 1957	
				24b. REGISTRAR'S SIGNATURE J. Lloyd Wolfe			

CERTIFICATE OF DEATH

STATE DEPARTMENT OF HEALTH

BUREAU V. 3

OCT 16 1957

RECEIVED

DR. BALLIN

10081

CERTIFICATE OF DEATH

Reg. Dist. No.

4

1. PLACE OF DEATH o. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. LENGTH OF STAY IN 1b 25 DAYS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First MORRIS Middle JOSEPH Last LIPSON				4. DATE OF DEATH Month OCT. Day 22 Year 1957			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/25/1869		9. AGE (In years and birthday) yrs. 87	IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SALESMAN		10b. KIND OF BUSINESS OR INDUSTRY Furniture Store		11. BIRTHPLACE (State or foreign country) POLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME BERNARD LIPSON				14. MOTHER'S MAIDEN NAME Rose (Unknown)			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO. 214-05-6325		17. INFORMANT Mrs. Anna Lipson		Address Cumb. Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Heart Disease 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH 2 years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 8-22 1955 to 10-22 1957 , that I last saw the deceased alive on 10-22 1957 , and that death occurred at 4:05A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 62 Greene St. 10-22-57							
ACTUAL SIGNATURE Louis W. Ballin M.D.				PHYSICIAN'S NAME (Type) DR. BALLIN Cumberland, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Burial		10/24/57		East View Cem.		Cumberland Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Louis Stein Sr.				ADDRESS Cumb. Md.		24b. REGISTRAR'S SIGNATURE W. Ross Cameron M.D. Acting Registrar	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

DR. EXAMINE

ALL COUNTY

22-1-13

MARYLAND HOSPITAL

CHIEF

JOHN

ELDER

WHITE

RECORDS SECTION

BUREAU V. A.

OCT 25 1957

RECEIVED

10082

CERTIFICATE OF DEATH

10100

4

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Knapp Meadow "Rural"	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Sacred Heart Hospital		d. STREET ADDRESS Lonaconing, Maryland	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Baby Middle Llewellyn Last Llewellyn		4. DATE OF DEATH Month October Day 23 Year 19 57	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 22, 1957
9. AGE (In years last birthday) 40		IF UNDER 1 YEAR Months 7 Days 40 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
		Cumberland, Maryland	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
U.S.A.			
13. FATHER'S NAME Samuel Llewellyn		14. MOTHER'S MAIDEN NAME Clara Steele	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) none	
17. INFORMANT Samuel Llewellyn		Address Rt 1, Frostburg, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Immaturity of vital functions 773.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
MEDICAL CERTIFICATION 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____ and that death occurred at _____ M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE Leland B. Ransom M.D. Leland B. Ransom 24 OCT 57 PHYSICIAN'S NAME (Type) Leland B. Ransom 63 Greene St. Cumberland, Md			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/24/57	
22c. NAME OF CEMETERY OR CREMATORY Mease Cemetery		22d. LOCATION (City, town, or county) (State) Lonaconing, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE George Eichhorn		ADDRESS Lonaconing, Md	
24a. REC'D BY REGISTRAR Oct. 24, 1957		24b. REGISTRAR'S SIGNATURE W. Ross Cameron, M.D. <i>Acting Registrar</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2062203XVO

CERTIFICATE OF DEATH

Name of Deceased		Age		Sex		Race		Color		Religion		Marital Status		Occupation		Cause of Death		Place of Death		Date of Death		Time of Death		Signature of Physician		Signature of Registrar		Signature of Coroner	
Samuel J. Steel		45		Male		White		Caucasian		Roman Catholic		Single		Carpenter		Heart Disease		Home		October 25, 1957		10:00 AM		[Signature]		[Signature]		[Signature]	
Place of Birth		Date of Birth		Date of Admission		Date of Discharge		Date of Death		Date of Burial		Date of Interment		Date of Cremation		Date of Autopsy		Date of Examination		Date of Postmortem		Date of Necropsy		Date of Toxicology		Date of Microbiology		Date of Histology	
Baltimore, Maryland		October 10, 1912		October 10, 1957		October 10, 1957		October 25, 1957		October 25, 1957		October 25, 1957		October 25, 1957		October 25, 1957		October 25, 1957		October 25, 1957		October 25, 1957		October 25, 1957		October 25, 1957		October 25, 1957	
Place of Death		Date of Death		Date of Admission		Date of Discharge		Date of Death		Date of Burial		Date of Interment		Date of Cremation		Date of Autopsy		Date of Examination		Date of Postmortem		Date of Necropsy		Date of Toxicology		Date of Microbiology		Date of Histology	
Home		October 25, 1957		October 10, 1957		October 10, 1957		October 25, 1957		October 25, 1957		October 25, 1957		October 25, 1957		October 25, 1957		October 25, 1957		October 25, 1957		October 25, 1957		October 25, 1957		October 25, 1957		October 25, 1957	
Cause of Death		Date of Death		Date of Admission		Date of Discharge		Date of Death		Date of Burial		Date of Interment		Date of Cremation		Date of Autopsy		Date of Examination		Date of Postmortem		Date of Necropsy		Date of Toxicology		Date of Microbiology		Date of Histology	
Heart Disease		October 25, 1957		October 10, 1957		October 10, 1957		October 25, 1957		October 25, 1957		October 25, 1957		October 25, 1957		October 25, 1957		October 25, 1957		October 25, 1957		October 25, 1957		October 25, 1957		October 25, 1957		October 25, 1957	
Place of Death		Date of Death		Date of Admission		Date of Discharge		Date of Death		Date of Burial		Date of Interment		Date of Cremation		Date of Autopsy		Date of Examination		Date of Postmortem		Date of Necropsy		Date of Toxicology		Date of Microbiology		Date of Histology	
Home		October 25, 1957		October 10, 1957		October 10, 1957		October 25, 1957		October 25, 1957		October 25, 1957		October 25, 1957		October 25, 1957		October 25, 1957		October 25, 1957		October 25, 1957		October 25, 1957		October 25, 1957		October 25, 1957	
Cause of Death		Date of Death		Date of Admission		Date of Discharge		Date of Death		Date of Burial		Date of Interment		Date of Cremation		Date of Autopsy		Date of Examination		Date of Postmortem		Date of Necropsy		Date of Toxicology		Date of Microbiology		Date of Histology	
Heart Disease		October 25, 1957		October 10, 1957		October 10, 1957		October 25, 1957		October 25, 1957		October 25, 1957		October 25, 1957		October 25, 1957		October 25, 1957		October 25, 1957		October 25, 1957		October 25, 1957		October 25, 1957		October 25, 1957	

RECEIVED
OCT 25 1957
BUREAU V. 2

CERTIFICATE OF DEATH

10101

Reg. Dist. No.

4

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> <u>Cumberland</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u> 02	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>415 Central Avenue</u>		d. STREET ADDRESS <u>415 Central Avenue</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>BLANCHE</u> Middle <u>MYRTLE</u> Last <u>LOGUE</u>		4. DATE OF DEATH Month <u>October</u> Day <u>15</u> Year <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>February 4, 1904</u>
9. AGE (In years last birthday) <u>53</u> yrs.		IF UNDER 1 YEAR Months <u>7</u> Days <u>15</u> Hours <u>19</u> Min. <u>57</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Rawlings, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William Norman</u>		14. MOTHER'S MAIDEN NAME <u>Ida Dawson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>Harley S. Logue</u>	
17. INFORMANT <u>Harley S. Logue</u>		Address <u>415 Central Avenue</u> <u>Cumberland, Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Carcinomatosis, Generalized</u> <u>155X</u> DUE TO <u>Carcinoma of gall bladder</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>7 mos</u> DUE TO (c) <u>7 mos</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>INTERVAL BETWEEN ONSET AND DEATH</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. g. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>3/14</u> , 19 <u>57</u> , to <u>10/15/57</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>10/14/57</u> , 19 <u>57</u> , and that death occurred at <u>2:00 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Fuller B. Whitworth</u> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED <u>Cumberland, Md.</u> <u>10/15/57</u>	
PHYSICIAN'S NAME (Type) <u>Fuller B. Whitworth M.D. 123 Bedford Street Cumberland, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>10/18/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Sunset Memorial Park</u>	22d. LOCATION (City, town, or county) (State) <u>Cumberland, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John J. Hafer, Cumberland, Maryland</u>		24a. REC'D BY REGISTRAR <u>Oct. 17, 1957</u>	24b. REGISTRAR'S SIGNATURE <u>W. Ross Cameron, M.D. Acting Registrar</u>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 3 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

• •

BUREAU V. S.

OCT 18 1957

RECEIVED

10102

CERTIFICATE OF DEATH

Reg. Dist. No.

10084

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland				c. LENGTH OF STAY IN 1b 15 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Sacred Heart Hospital				e. STREET ADDRESS 313 Caroline Street			
3. NAME OF DECEASED (Type or print) First De Sales Middle Mattingly Last 62				4. DATE OF DEATH Month October Day 5 Year 19 57			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12/11/94	
9. AGE (In years last birthday) 62 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter				10b. KIND OF BUSINESS OR INDUSTRY Self Employed		11. BIRTHPLACE (State or foreign country) Pennsylvania	
12. CITIZEN OF WHAT COUNTRY? -All USA							
13. FATHER'S NAME James T. Mattingly				14. MOTHER'S MAIDEN NAME Rose Ella Topper			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no				16. SOCIAL SECURITY NO. 219-03-8331		17. INFORMANT Patient's Chart	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PNEUMONIA = HYPOSTATIC TYPE DUE TO PULMONARY EDEMA Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) PULMONARY INFARCTION (c) MYOCARDIAL INFARCTION (5 years) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) HYPERTENSIVE + ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that I attended the deceased from 19 56 , to Oct 5, 19 57 , that I last saw the deceased alive on Oct 5, 19 57 , and that death occurred at 9:05 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 59 GREENE ST DATE SIGNED 10/6/57 ACTUAL SIGNATURE S. G. Weisman M.D. CUMBERLAND, MD PHYSICIAN'S NAME (Type) S. G. Weisman, M. D. 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 22b. DATE THEREOF 10-8-57 22c. NAME OF CEMETERY OR CREMATORY St. Mary's Cemetery 22d. LOCATION (City, town, or county) (State) Cumberland, Md. 23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli, Cumberland, Md. 24a. REQ'D BY REGISTRAR Oct 7, 1957 24b. REGISTRAR'S SIGNATURE W. Ross Cameron, M.D. Acting Registrar							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH	
JAMES J. JONES		35		M		W		1920		BALTIMORE, MD.	
MARRIED		WIFE		NAME		AGE		DATE OF MARRIAGE		PLACE OF MARRIAGE	
MARRIED		JANE J. JONES		30		F		1945		BALTIMORE, MD.	
OCCUPATION		CAUSE OF DEATH		PERIOD OF ILLNESS		PLACE OF DEATH		DATE OF DEATH		TIME OF DEATH	
LABORER		HEART DISEASE		2 WEEKS		HOME		OCT 5, 1957		10:00 AM	
EDUCATION		SIGNED AND SWORN TO before me this		DATE		PLACE		BY ME		MY COMMISSION EXPIRES	
HIGH SCHOOL		OCT 5, 1957		BALTIMORE, MD.		J. J. JONES		NOTARY PUBLIC		BALTIMORE, MD.	
SIGNED AND SWORN TO before me this		DATE		PLACE		BY ME		MY COMMISSION EXPIRES			
OCT 5, 1957		BALTIMORE, MD.		J. J. JONES		NOTARY PUBLIC		BALTIMORE, MD.			

BUREAU V. 3

OCT 8 1957

RECEIVED

10140

CERTIFICATE OF DEATH

10103

Reg. Dist. No. 4

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural, Route 3,				c. LENGTH OF STAY IN 1b 50 years			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) x2 Rural Route 3, Cumberland, Md.							
d. NAME OF HOSPITAL (If in hospital, give street address) OR INSTITUTION Bedford Road				d. STREET ADDRESS Bedford Road			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First CATHERINE Middle B. Last MAYO				4. DATE OF DEATH Month Oct. Day 11, Year 1957			
5. SEX Felame White		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb. 6, 1886m	
9. AGE (In years last birthday) 71 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Buchanan, W. Va.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John N. Thorne				14. MOTHER'S MAIDEN NAME Laverna Hostetter			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Gladys Mayo, Rt. 3, Cumberland, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Angina Pectoris 420.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arterial Hypertension DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 3 months 2 years					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 2 , 19 57 , to Oct 11 , 19 57 , that I last saw the deceased alive on Oct 10 , 19 57 , and that death occurred at 6 P M , from the causes and on the date stated above.							
ACTUAL SIGNATURE R. W. Trepaskis, Sr M.D.				ADDRESS (Street, city or town, state) Cumberland, Md DATE SIGNED Oct 12-1957			
PHYSICIAN'S NAME (Type) R. W. TREPASKIS, SR				Cumberland, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10-14, 1957		22c. NAME OF CEMETERY OR CREMATORY Zion Memorial Cemetery		22d. LOCATION (City, town, or county) (State) Cumberland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Byron Kight, Cumberland, Md.				24a. REC'D BY REGISTRAR Oct 12, 1957		24b. REGISTRAR'S SIGNATURE W. Ross Cameron, M.D. <i>Acting Registrar</i>	

Outside of City limits

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in, the funeral director or funeral home should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form with multiple fields for death certificate information, including name, date, and location. The text is mirrored and difficult to read.

BUREAU V. S.

OCT 15 1954

RECEIVED

Form with fields for signature and date, including the name "BAYON KIKOT" and the date "OCT 15 1954".

10120

CERTIFICATE OF DEATH

Reg. Dist. No.

9

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg				c. LENGTH OF STAY IN 1b x2 Nikep			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Miners Hospital				d. STREET ADDRESS 1			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Michael Middle F. Last McCabe				4. DATE OF DEATH Month October Day 1 Year 19 57			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 16, 1877		9. AGE (In years last birthday) 80 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Coal		10b. KIND OF BUSINESS OR INDUSTRY Miner		11. BIRTHPLACE (State or foreign country) Pekin, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Michael McCabe				14. MOTHER'S MAIDEN NAME Margaret Henry			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 182-01-6441A		17. INFORMANT Angela McCabe		Address Nikep, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 204.0 Congestive Heart failure DUE TO (b) Chronic lymphatic leukemia Conditions, if any, which gave rise to immediate case (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH years years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 19 56 to Oct 19 57 , that I last saw the deceased alive on Oct 19 57 , and that death occurred at 9:10 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Leslie R. Miles				ADDRESS (Street, city or town, state) Lonaconing, Md.			
PHYSICIAN'S NAME (Type) George Eichhorn				DATE 10-4-57			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/4/57		22c. NAME OF CEMETERY OR CREMATORY St Gabriels Cemetery		22d. LOCATION (City, town, or county) (State) Barton, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE George Eichhorn				24a. REC'D BY REGISTRAR 10-4-57		24b. REGISTRAR'S SIGNATURE Mrs. Nancy H. Poe	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 3 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Name of Deceased		Sex		Age	
John Doe		Male		35	
Date of Death		Place of Death		Cause of Death	
October 10, 1957		Home		Heart Disease	
Signature of Physician		Signature of Registrar		Signature of Coroner	
[Signature]		[Signature]		[Signature]	
City		County		State	
Baltimore		Baltimore		Maryland	
Date of Report		Signature of Reporting Officer		Signature of Medical Examiner	
October 11, 1957		[Signature]		[Signature]	
City		County		State	
Baltimore		Baltimore		Maryland	

BUREAU V. 2

OCT 11 1957

RECEIVED

10085

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH a. COUNTY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Cumberland, Md. b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland				c. LENGTH OF STAY IN 1b 02			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Sacred Heart Hospital				e. STREET ADDRESS 133 Bedford St.			
3. NAME OF DECEASED (Type or print) Thomas James McDaniel				4. DATE OF DEATH 10-23-57			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug 25, 1887	
9. AGE (In years last birthday) 60 yrs.		10. IF UNDER 1 YEAR: Months 10 Days 23 Hours 57 Min.		11. AGE (In years last birthday) 60 yrs.		12. IF UNDER 24 HRS. Months 10 Days 23 Hours 57 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Telegraph Operator				10b. KIND OF BUSINESS OR INDUSTRY B & O.			
11. BIRTHPLACE (State or foreign country) Penna				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Thomas J. McDaniels				14. MOTHER'S MAIDEN NAME Emily Hale			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give year of entry and service) WW I				16. SOCIAL SECURITY NO. 705-09-9700			
17. INFORMANT Patients chart				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Pancreas DUE TO 157x Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 2 months DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 157x							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year 19				20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from July 1957 , to 10/23/57 , that I last saw the deceased alive on 10/23/57 , and that death occurred at M from the causes and on the date stated above.							
ACTUAL SIGNATURE B. M. Schindler M.D.				ADDRESS (Street, city or town, state) 43 Greenbush Ave., Md. DATE SIGNED 10/15/57			
PHYSICIAN'S NAME (Type) Dr. P. Schindler M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/26/57		22c. NAME OF CEMETERY OR CREMATORY Rest Lawn Mem. Garden		22d. LOCATION (City, town, or county) (State) La Vale Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Louis Stein Inc. ADDRESS Cum. Md.				24. REC'D BY REGISTRAR Oct. 26, 1957 24b. REGISTRAR'S SIGNATURE W. Ross Cameron, M.D. Acting Registrar			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 3 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 15

11-01-44

BUREAU V. 8

OCT 29 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10086

CERTIFICATE OF DEATH

10106

Reg. Dist. No. 4

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland,		c. LENGTH OF STAY IN 1b 02 Cumberland,	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 123 N. Centre St.,		d. STREET ADDRESS 123 N. Centre St.,	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First EDNA Middle MARIE Last McKALVEY		4. DATE OF DEATH Month Oct. Day 19 Year 19 57	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH June 26, 1917
9. AGE (In years lost birthday) 40 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waitress		10b. KIND OF BUSINESS OR INDUSTRY Restaurant	
11. BIRTHPLACE (State or foreign country) Cumberland, Md.		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Irving F. Laurent		14. MOTHER'S MAIDEN NAME Kathleen Kane	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No,		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	
17. INFORMANT Mr. Irving F. Laurent		Address 123 N. Centre St., Cumb. Md	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute cardiac collapse DUE TO (b) Malnutrition DUE TO (c) Influenza & virus infection PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic myocarditis		INTERVAL BETWEEN ONSET AND DEATH Sudden 3 yrs 12 days	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan , 19 52 , to Oct 19 , 19 57 , that I last saw the deceased alive on Oct 19 , 19 57 , and that death occurred at 2:05 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Lysle R. Everhart M.D.		ADDRESS (Street, city or town, state) La Vale, Maryland	
PHYSICIAN'S NAME (Type) Lysle Everhart M. D.		DATE SIGNED 10/21/57	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 10/22/57	22c. NAME OF CEMETERY OR CREMATORY St. Mary's Cemetery	22d. LOCATION (City, town, or county) (State) Cumberland, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Charles L. George		ADDRESS Cumberland, Md.	
24a. REC'D BY REGISTRAR 10/21/57		24b. REGISTRAR'S SIGNATURE W. Ross Cameron M.D. Acting Registrar	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

RECEIVED
OCT 22 1957
BUREAU V. S.

10087

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

4

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



60

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Allegany</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>		c. LENGTH OF STAY IN 1b <u>5 days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Memorial Hospital</u>		d. STREET ADDRESS <u>202 Springdale St.</u>	
3. NAME OF DECEASED (Type or print) <u>Adam Truman Mencer</u>		4. DATE OF DEATH Month <u>Oct.</u> Day <u>10</u> Year <u>19 57</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 4-1902</u>
9. AGE (In years last birthday) <u>55</u> yrs.		IF UNDER 1 YEAR Months <u></u> Days <u></u> IF UNDER 24 HRS. Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Construction foreman-Geo. F. Hazelwood</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Great Capon, W. Va.</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Mencer</u>		14. MOTHER'S MAIDEN NAME <u>Etta Hardy</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>212-10-3566</u>	
17. INFORMANT <u>Memorial Hospital records & wife.</u>		Address <u></u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary edema (marked)</u> <u>916.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>2nd, 3rd, & 4th degree burns, 40 % of body surface-</u> (c) <u>from belt line up, anterior surface, including arms & head. Hydrothorax.</u> DUE TO INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Working on auto, went in house for a short time, came out on back porch with his clothes on fire. Unable to explain how it</u>	
20c. TIME OF INJURY Month, Day, Year <u>5</u> Hour <u>5:00</u> <u>Oct. 5</u> 19 <u>57</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>	20f. (City or town) (County) happened at <u>Cumberland, Allegany, Md.</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>H. V. Deming M.D.</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>H. V. Deming M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Oct. 13, 1957</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Nebo Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Great Cacapon, West Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>James F. Scarpelli, Cumberland, Maryland.</u>		24a. REC'D BY REGISTRAR <u>Oct. 15, 1957</u>	
		24b. REGISTRAR'S SIGNATURE <u>W. Ross Cameron M.D. Acting Registrar</u>	

BUREAU V. 5

OCT 17 1957

RECEIVED

Outside of
City Limits

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10108

10141

CERTIFICATE OF DEATH

Reg. Dist. No.

4

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland, Rural		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) x2 Cumberland, Rural	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 23 Morning Side Drive, R.F.D. #3		d. STREET ADDRESS 23 Morning Side Drive, R.F.D. #3	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Elizabeth Middle Henrietta Last Metzger		4. DATE OF DEATH Month Oct. Day 17 Year 1957	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 24, 1874
9. AGE (In years last birthday) yrs. 83		IF UNDER 1 YEAR, IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own home	
11. BIRTHPLACE (State or foreign country) Hoffman, Md.		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Thomas Higgins		14. MOTHER'S MAIDEN NAME Mary Baxter	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Vincent Metzger		Address 23 Morning Side Drive, Cumb. Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebro Vascular Accident DUE TO 332x Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) Generalized Interconvulsions DUE TO year (c) year		INTERVAL BETWEEN ONSET AND DEATH 7 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 10/1/57 , to 10/17/57 , that I last saw the deceased alive on 10/1/57 , and that death occurred at 11:55 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE George M. Simons M.D.		ADDRESS (Street, city or town, state) 128 Union St., Cumberland, Md.	
DATE SIGNED 10/18/57			
PHYSICIAN'S NAME (Type) George M. Simons M. D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/21/57	
22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		22d. LOCATION (City, town, or county) (State) Cumberland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Charles L. George		ADDRESS Cumberland, Md.	
24a. REC'D BY REGISTRAR Oct. 19, 1957		24b. REGISTRAR'S SIGNATURE W. Ross Cameron, M.D. <i>Acting Registrar</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, it should be filed with the page could be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

BUREAU V. S.

OCT 22 1957

RECEIVED

STATE OF MARYLAND DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 11, Film G222, 11/1/57 fcy

10109

10142

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural, Cumberland				c. LENGTH OF STAY IN 1b 35 yrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION R. D. No 5				d. STREET ADDRESS R. D. No 5			
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Miss Middle Ella Last Metzner				4. DATE OF DEATH Month 10 Day 23 Year 1957			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10-3-1874	
9. AGE (In years last birthday) 83 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House work				10b. KIND OF BUSINESS OR INDUSTRY Sister's Home		11. BIRTHPLACE (State or foreign country) R.F.#1, Hoffman, Frostburg	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME Henry Metzner				14. MOTHER'S MAIDEN NAME Ella Ellen Moody			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No.				16. SOCIAL SECURITY NO. None			
17. INFORMANT Cumberland, Md. Address Mary L. Grabenstein, Niece R. D. No 5							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Uterus DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.						INTERVAL BETWEEN ONSET AND DEATH 10 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Hypertension							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 1947 to 10-23 , 1957, that I last saw the deceased alive on 10-23 , 1957, and that death occurred at 2:40 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 16 Green St DATE SIGNED 10-24-57							
ACTUAL SIGNATURE J. J. Johnson M.D.							
PHYSICIAN'S NAME (Type) Dr. James T. Johnson, Jr. Cumberland Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10-26-1957		22c. NAME OF CEMETERY OR CREMATORY St. Michael's Cemetery		22d. LOCATION (City, town, or county) (State) Frostburg Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Pearl H. Waltinger ADDRESS 25 E. Main Street				24a. REC'D BY REGISTRAR DATE 10-26-57		24b. REGISTRAR'S SIGNATURE Miss. Nancy H. De	

CERTIFICATE OF DEATH

BUREAU V. 2

OCT 22 1931

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10143

CERTIFICATE OF DEATH

Reg. Dist. No.

10119

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Woodland		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Woodland	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Rt. 1, Frostburg, Md.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First George Middle William Last Miller		4. DATE OF DEATH Month October Day 27 Year 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 24, 1884
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) 73 yrs.
11. BIRTHPLACE (State or foreign country) Gilmore, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George Miller		14. MOTHER'S MAIDEN NAME Victoria Buskirk	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT George Miller Jr		Address Woodland, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis, right 442x DUE TO (b) Cardiovascular Renal disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 10 days 5-10 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 10/17 , 19 57 , to 10/27 , 19 57 , that I last saw the deceased alive on 10/25/57 , 19 57 , and that death occurred at 4:00 p. m., from the causes and on the date stated above.			
ACTUAL SIGNATURE Hilda Jane Walters, M. D.		ADDRESS (Street, city or town, state) 48 Broadway, Frostburg, Md. DATE SIGNED 10/28/57	
PHYSICIAN'S NAME (Type) Hilda Jane Walters, M. D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 10/30/57	22c. NAME OF CEMETERY OR CREMATORY Oak Hill Cemetery	22d. LOCATION (City, town, or county) (State) Lonaconing, Md.
23. FUNERAL DIRECTOR'S SIGNATURE George Eichhorn		ADDRESS Lonaconing, Md.	
24a. REC'D BY REGISTRAR 10-30-57		24b. REGISTRAR'S SIGNATURE Mrs. Mary N. Lee	

CERTIFICATE OF DEATH

DECEASED NAME George William		SEX Male	
AGE 42		DATE OF BIRTH 1898	
PLACE OF BIRTH Baltimore, Md.		OCCUPATION Clerk	
MARITAL STATUS Married		DATE OF MARRIAGE 1925	
NAME OF SPOUSE Mary		PLACE OF MARRIAGE Baltimore, Md.	
DATE OF DEATH 1940		PLACE OF DEATH Baltimore, Md.	
CAUSE OF DEATH Heart Disease		MANNER OF DEATH Natural	
SIGNATURE OF PHYSICIAN [Signature]		SIGNATURE OF REGISTRAR [Signature]	
CITY Baltimore		COUNTY Baltimore	
STATE Maryland		ZIP CODE 21201	

BUREAU V. S.

NOV 5 1940

RECEIVED

20/30/40

George William

Baltimore, Md.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

VS. A15ME
SM 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10144 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11367

Reg. Dist. No. 8

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Allegany</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Midland</u>		c. LENGTH OF STAY IN 1b <u>Rural-Midland X2</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural-Midland X2</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>In creek near home</u>			d. STREET ADDRESS <u>1</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Louis</u> Middle <u>Jacob</u> Last <u>Miller</u>			4. DATE OF DEATH about <u>Oct. 24</u> Day <u>24</u> Year <u>1957</u>		
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 4-1902</u>	9. AGE (In years last birthday) <u>55</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Coal miner & Laborer</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Lonaconing, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>Louis Miller</u>			14. MOTHER'S MAIDEN NAME <u>Margaret Nee Lochner</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mrs. Delbert Fazenbaker</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO (b) <u>Coronary sclerosis (marked)</u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (c) <u>Cardiac hypertrophy (marked)</u>					INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u> <u>?</u> <u>?</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>1</u>	
20f. (City or town) <u>1</u>		20g. (County) <u>1</u>		20h. (State) <u>1</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>H.V. Deming M.D.</u>		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>H.V. Deming M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>Nov. 7-1957</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11/8/1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Oak Hill Cemetery</u>	
22d. LOCATION (City, town, or county) <u>Lonaconing, MD.</u>				(State) <u>MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>George Eichhorn,</u>		ADDRESS <u>Lonaconing, MD.</u>		24a. REC'D BY REGISTRAR DATE <u>11/9/57</u>	
				24b. REGISTRAR'S SIGNATURE <u>Jennette M Boal</u>	

MASSACHUSETTS DEPARTMENT OF HEALTH - BUREAU OF
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

STATE OF MASSACHUSETTS
DEPARTMENT OF HEALTH

Form with multiple sections for recording death information, including fields for name, date, time, place, cause, and signature. The form is partially filled out with handwritten text.

BUREAU V. 8

NOV 14 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10145

CERTIFICATE OF DEATH

10111

Reg. Dist. No. 8

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lonaconing				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Railroad Street				d. STREET ADDRESS Railroad Street			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Florence Middle Bell Last Morgan				4. DATE OF DEATH Month October Day 14 Year 19 57			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 12, 1875		9. AGE (In years last birthday) 82 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Amos Minear				14. MOTHER'S MAIDEN NAME Mary Ridenour			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. [If yes, give war or dates of service]		17. INFORMANT Mrs. Edna Swift Lonaconing, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis DUE TO "Daughter" Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Heart Disease DUE TO 10 yrs - (c) Recurrent PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Recurrent							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 6/6/57 , 19 57 to 10/14 , 19 57 that I last saw the deceased alive on 10/14/57 , 19 57 , and that death occurred at 10:00 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 48 BROADWAY DATE SIGNED ACTUAL SIGNATURE Martin M. Rothstein M.D. PHYSICIAN'S NAME (Type) MARTIN M. ROTHSTEIN M.D. FROSTBURG - MD.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/17/57		22c. NAME OF CEMETERY OR CREMATORY Terra Alta Cemetery		22d. LOCATION (City, town, or county) (State) Terra Alta, W.Va.	
23. FUNERAL DIRECTOR'S SIGNATURE George Eichhorn				ADDRESS Lonaconing, Md.		24a. REC'D BY REGISTRAR DATE 10/19/57	
				24b. REGISTRAR'S SIGNATURE Janette M. Boal			

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

47
10

Name of Deceased		Sex		Age		Date of Birth	
James Kline		Male		35		1922	
Place of Birth		Race		Color		Religion	
Baltimore, Md.		White		White		Roman Catholic	
Married		Single		Widow		Divorced	
Married		Single		Widow		Divorced	
Cause of Death		Duration of Illness		Place of Death		Date of Death	
Heart Disease		3 weeks		Home		Oct 25, 1957	
Signature of Physician		Signature of Registrar		Signature of Informant		Signature of Informant	
[Signature]		[Signature]		[Signature]		[Signature]	

BUREAU V. S.

OCT 28 1957

RECEIVED

Name of Informant		Relationship to Deceased		Address		City	
George Kline		Son		1234 Main St.		Baltimore, Md.	
Signature of Informant		Signature of Registrar		Signature of Informant		Signature of Informant	
[Signature]		[Signature]		[Signature]		[Signature]	

10

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10112

10088

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Allegany</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>	c. LENGTH OF STAY IN 1b <u>3 months</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>02 Cumberland</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>400 Decatur St.</u>		d. STREET ADDRESS <u>1400 Decatur St.</u>	
3. NAME OF DECEASED (Type or print) <u>Jennie</u> <u>Mowery</u>		4. DATE OF DEATH Month <u>Oct.</u> Day <u>18</u> Year <u>1957</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 28-1874</u>
9. AGE (In years last birthday) <u>82</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Corn Rone</u>	
11. BIRTHPLACE (State or foreign country) <u>Independence, Iowa</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles Johnson</u>		14. MOTHER'S MAIDEN NAME <u>Clarindo Woodward</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>(so) Harry A. Stevens, Sioux, S. Dakota</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial failure</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic cardio-vascular disease</u> DUE TO (c) <u>Hypertention</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>INTERVAL BETWEEN ONSET AND DEATH</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>H. V. Deming M.D.</u>		DATE SIGNED	
EXAMINER'S NAME (Type) <u>H. V. Deming M.D.</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>Oct. 18-1957</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>10/22 57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Beres Ford Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Beres Ford S.D.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>H. Lee Silcox</u>		ADDRESS <u>Cumberland, Md.</u>	
24a. REC'D BY REGISTRAR <u>Oct 19, 1957</u>		24b. REGISTRAR'S SIGNATURE <u>W. Ross Cameron M.D.</u> <u>Acting Registrar</u>	

OCT 22 1957

BUREAU V. S.

CERTIFICATE OF DEATH

10113
4

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. LENGTH OF STAY IN 1b 02 CUMBERLAND			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL				d. STREET ADDRESS 208 INDEPENDENCE ST.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First THOMAS Middle ALEXANDER Last NEFF				4. DATE OF DEATH Month OCTOBER Day 18 Year 19 57			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH APRIL 2, 1892		9. AGE (In years last birthday) 65 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working-life, even if retired) Retired Employee		10b. KIND OF BUSINESS OR INDUSTRY Pool Room		11. BIRTHPLACE (State or foreign country) CUMBERLAND, MD.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME EDWARD R. NEFF				14. MOTHER'S MAIDEN NAME MARGARET MCKEE			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 214-16-2882		17. INFORMANT MEMORIAL HOSPITAL		Address CUMBERLAND, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Failure Chr Myocarditis 422.2 DUE TO Cor Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cor DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Collitis (Mucous)						INTERVAL BETWEEN ONSET AND DEATH 1 yr	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 10/4/55 , 19 to 10/18/57 , 19, that I last saw the deceased alive on 10/18/57 , 19, and that death occurred at 7:40 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, State) Cumberland, Maryland DATE SIGNED 10/20/57 ACTUAL SIGNATURE R. J. Williams M.D. PHYSICIAN'S NAME (Type) DR. R. J. WILLIAMS							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/21/57		22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		22d. LOCATION (City, town, or county) (State) Cumberland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer, Cumberland, Maryland				24. REC'D BY REGISTRAR Oct 21, 1957		24b. REGISTRAR'S SIGNATURE W. Ross Cameron, M.D. <i>Acting Registrar</i>	

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18

1957

10-28-57

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C. STRAND

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BUREAU V. S.

OCT 22 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Pages 1 and 2 should be filled with the funeral director.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 7 Film G222 11-4-57 et

CERTIFICATE OF DEATH

10114

Reg. Dist. No.

10090

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 6 yr. 2 mo. 24 da.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Sylvan Retreat, Furnace St.				d. STREET ADDRESS 201 Baltimore Street					
3. NAME OF DECEASED (Type or print) First John Middle W. Last Nicholas				4. DATE OF DEATH Month 10 Day 27 Year 1957					
5. SEX Male	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/17/80		9. AGE (In years lost birthday) 77 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.		
10a. MALE OCCUPATION (Give kind of work done during most of working life, even if retired) Railroader		10b. KIND OF BUSINESS OR INDUSTRY Laborer		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Edward Nicholas				14. MOTHER'S MAIDEN NAME Clarsie E. Martin					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Address Sylvan Retreat Cumberland, Md.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Myocarditis 592X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cerebral arteriosclerosis DUE TO (c) Chronic Nephritis								INTERVAL BETWEEN ONSET AND DEATH ?	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Severe psychosis								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from Aug. 31st, 1951 , to Oct. 27th, 1957 , that I last saw the deceased alive on Oct. 26th, 1957 , and that death occurred at 10:25 A.M. from the causes and on the date stated above.									
ACTUAL SIGNATURE James E. McLean				ADDRESS (Street, city or town, state) 49 Greene St.		DATE SIGNED 10/28/57			
PHYSICIAN'S NAME (Type) James E. McLean									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/29/57		22c. NAME OF CEMETERY OR CREMATORY St. Patricks Cem.		22d. LOCATION (City, town, or county) (State) Cumberland, Md.			
23. FUNERAL DIRECTOR'S SIGNATURE H. Lee Silcox				ADDRESS Cumberland, Md.		24a. REC'D BY REGISTRAR Oct 29, 1957			
				24b. REGISTRAR'S SIGNATURE W. Ross Cameron, M.D.		Acting Registrar			

RECEIVED
OCT 30 1957
BUREAU V. 8

DR. R.J. WILLIAMS

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN TB 1 DAYS	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) XO CUMBERLAND, rural		d. STREET ADDRESS 1 RT. #1, LaVale	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First VIRGIL Middle CAUDY Last NIXON		4. DATE OF DEATH Month OCTOBER Day 5 Year 19 57	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH FEB. 3, 1893
9. AGE (In years last birthday) 64 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOSTLER		10b. KIND OF BUSINESS OR INDUSTRY B. & O. R.R.CO.	11. BIRTHPLACE (State or foreign country) PAW PAW, W.VA.
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME JAMES EDWARD NIXON	
14. MOTHER'S MAIDEN NAME MARTHA L. HARDY		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unknown) (If yes, give war or dates of service) No	
16. SOCIAL SECURITY NO.		17. INFORMANT MEMORIAL HOSPITAL - CUMBERLAND, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 MYOCARDIAL INFARCTION DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) MYOCARDIAL INFARCTION DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 1 month, 6 weeks		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 10/10/57, 19 to 10/13/57, 19, that I last saw the deceased alive on 10/13/57, 19, and that death occurred at 6:12 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE DR. R.J. WILLIAMS		ADDRESS (Street, city or town, state) DATE SIGNED 10/13/57	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 10/7/57	22c. NAME OF CEMETERY OR CREMATORY White Oak Cemetery	22d. LOCATION (City, town, or county) (State) Nr. Wellersburg, Penn
23. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer, Cumberland, Maryland		24. REC'D BY REGISTRAR DATE Oct. 8, 1957	
		24b. REGISTRAR'S SIGNATURE W. Ross Cameron, M.D. Acting Registrar	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		DATE OF DEATH	
SEX		AGE	
RACE		EDUCATION	
MARRIAGE		OCCUPATION	
PLACE OF BIRTH		PLACE OF DEATH	
CAUSE OF DEATH		MANNER OF DEATH	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR	
DATE OF SIGNATURE		DATE OF SIGNATURE	

RECEIVED
OCT 10 1957
BUREAU V. 2

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10121

CERTIFICATE OF DEATH

10116

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Garrett	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural, near Frostburg, Md. 11x1.2	
c. LENGTH OF STAY IN IB 4 days		d. STREET ADDRESS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Niner's Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ROSA Middle MAE Last PAIGE		4. DATE OF DEATH Month October Day 19 Year 57	
5. SEX Female	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH February 28, 1913
9. AGE (In years last birthday) 44 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY Private Residence Frostburg, Maryland	
11. BIRTHPLACE (State or foreign country) USA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Douglas J. Paige		14. MOTHER'S MAIDEN NAME Rosia Redmond	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 212-24-1282	
17. INFORMANT Mrs. Rosia Kelley, Frostburg, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ATYPICAL PNEUMONIA 492x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) BRONCHIAL ASTHMA		INTERVAL BETWEEN ONSET AND DEATH 48 HRS.	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from OCT-17 , 19 57 , to OCT-19 , 19 57 , that I last saw the deceased alive on OCT-19 , 19 57 , and that death occurred at 3:30 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Martin M. Rothstein M.D.		ADDRESS (Street, city or town, state) 48 BROADWAY DATE SIGNED 10/22/57	
PHYSICIAN'S NAME (Type) MARTIN M. ROTHSTEIN M.D.		FROSTBURG - MD.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 10/22/57	22c. NAME OF CEMETERY OR CREMATORY Frostburg Memorial Park	22d. LOCATION (City, town, or county) (State) Frostburg, Md.
23. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer, Cumberland, Md.		24a. REC'D BY REGISTRAR DATE 10/22/57	
		24b. REGISTRAR'S SIGNATURE Wm. Stanley N. Re	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

OCT 28 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 3 and 4 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

10146		MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18		10117	
Item 3, Film G-222 11/18/57.				CERTIFICATE OF DEATH	
1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE	
Allegany		MARYLAND		Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg, Route 1		c. LENGTH OF STAY IN 1b life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) x o Frostburg, Route 1	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. STREET ADDRESS 1		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) SALLIE First M. Middle (HOBLITZELL) PARKER		4. DATE OF DEATH Oct. 7, 19 57			
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-22-1872	9. AGE (In years last birthday) 85 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housework		10b. KIND OF BUSINESS OR INDUSTRY own home		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME William S. Hoblitzell		14. MOTHER'S MAIDEN NAME Margaret Shearer		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. none		17. INFORMANT Helen Parker, Rt. 1, Frostburg, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arterio Sclerosis 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Carcinoma of Breast				INTERVAL BETWEEN ONSET AND DEATH Several years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1954, 19, to Oct 7, 1957, that I last saw the deceased alive on Oct 1, 1957, and that death occurred at 12:20 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED W O McLane M.D. E. Main St., Frostburg, Md.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10-9-57		22c. NAME OF CEMETERY OR CREMATORY F'bg. Memorial Park	
23. FUNERAL DIRECTOR'S SIGNATURE J. R. Durst,		ADDRESS Frostburg, Md.		24a. REC'D BY REGISTRAR DATE 10-9-57	
				24b. REGISTRAR'S SIGNATURE Miss. Nancy H. De	

CERTIFICATE OF DEATH

1. NAME OF DECEASED JAMES EARL RAY		2. SEX Male		3. AGE 35		4. DATE OF DEATH April 4, 1968	
5. PLACE OF DEATH Room 306, Sheraton Hotel, Memphis, Tennessee		6. CAUSE OF DEATH Shot		7. MANNER OF DEATH Suicide		8. PLACE OF BIRTH Sikeston, Missouri	
9. OCCUPATION Attorney		10. EDUCATION High School		11. RELIGION Methodist		12. MARITAL STATUS Single	
13. SIGNATURE OF DECEASED (None)		14. SIGNATURE OF NEXT OF KIN None		15. SIGNATURE OF PHYSICIAN None		16. SIGNATURE OF CORONER None	
17. SIGNATURE OF REGISTRAR None		18. SIGNATURE OF CLERK None		19. SIGNATURE OF JURY None		20. SIGNATURE OF JUDGE None	

BUREAU V. 3

OCT 11 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 6 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

DR. JAMES

10092

CERTIFICATE OF DEATH

10118

Reg. Dist. No. 4

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE WEST VIRGINIA b. COUNTY MINERAL	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RIDGELEY, W.VA. 85X-3	
c. LENGTH OF STAY IN 1b 9 DAYS		d. STREET ADDRESS RT. #1	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First HARPER Middle O. Last PEER		4. DATE OF DEATH Month OCTOBER Day 26 Year 19 57	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JANUARY 24, 1890
9. AGE (In years last birthday) 67 yrs.		10. IF UNDER 1 YEAR: Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED Carpenter Self Emp.		10b. KIND OF BUSINESS OR INDUSTRY WEST VIRGINIA Hardy Co. U.S.A.	
11. BIRTHPLACE (State or foreign country) WEST VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James PEER		14. MOTHER'S MAIDEN NAME REBECCA JANE Lambert	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 214-05-9571	
17. INFORMANT MEMORIAL HOSPITAL - CUMBERLAND, MD.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage DUE TO 443X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive Cardiovascular disease DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH 7 days			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Oct 18 , 19 57 , to Oct 26 , 19 57 , that I last saw the deceased alive on Oct 25 , 19 57 , and that death occurred at 2:50 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 441 N. Center St. Cumberland Md. DATE SIGNED 10-28-57			
ACTUAL SIGNATURE William P. James M.D.			
PHYSICIAN'S NAME (Type) DR. W.P. JAMES			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10-29-57	
22c. NAME OF CEMETERY OR CREMATORY Fort Ashby Cem.		22d. LOCATION (City, town, or county) (State) Fort Ashby W.Va.	
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli		ADDRESS Cumberland, Md.	
24a. REC'D BY REGISTRAR DATE 29, 1957		24b. REGISTRAR'S SIGNATURE W. Ross Cameron, M.D. <i>Acting Registrar</i>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12. THE

BUREAU V. S.

OCT 30 1957

RECEIVED

10122

CERTIFICATE OF DEATH

Reg. Dist. No.

9

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg				c. LENGTH OF STAY IN 1b Lifetime			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 300 E. Main St.				d. STREET ADDRESS 300 E. Main Street			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Louise Middle L. Last Rank				4. DATE OF DEATH Month Oct Day 20 Year 1957			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 16th, 1898		9. AGE (In years last birthday) 58 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Teacher				10b. KIND OF BUSINESS OR INDUSTRY Beall High School		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME David C. Llewellyn				14. MOTHER'S MAIDEN NAME Jennie Hansel			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. 212-38-5738			
17. INFORMANT Lawrence Rank, 300 E. Main St., Md.				Address Frostburg,			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 356.1 Amyotrophic Lateral Sclerosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH 11 mo
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from Dec 1, 1956 to Oct 20, 1957 , that I last saw the deceased alive on Oct 19, 1957 , and that death occurred at 10:45 M, from the causes and on the date stated above.							
ACTUAL SIGNATURE WOMC Lane M.D.				ADDRESS (Street, city or town, state) Frostburg, Md.			
DATE SIGNED Oct 21, 1957							
PHYSICIAN'S NAME (Type) WOMC Lane							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10-22-57		22c. NAME OF CEMETERY OR CREMATORY F'bg. Memorial Park		22d. LOCATION (City, town, or county) (State) Frostburg, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Joseph R. Durst, Frostburg, Md.				24a. REC'D BY REGISTRAR DATE 10-22-57		24b. REGISTRAR'S SIGNATURE Miss Nancy N. Rose	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form with multiple sections for recording death information, including fields for name, date, cause of death, and location. The form is mostly blank with some faint markings.

BUREAU V. S.

OCT 28 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10093

CERTIFICATE OF DEATH

10120

Reg. Dist. No.

Within corporate limits

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 Cumberland	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 109 Decatur Street		d. STREET ADDRESS 109 Decatur Street	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First William Middle Robinette Last		4. DATE OF DEATH Month October Day 15 Year 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 27, 1866
9. AGE (In years last birthday) 91 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Miller		10b. KIND OF BUSINESS OR INDUSTRY Roher Milling Co.	
11. BIRTHPLACE (State or foreign country) Irons Mountain, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Gillis Robinette		14. MOTHER'S MAIDEN NAME Amanda Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs. Carrie Robinette Cumberland, Maryland		Address 109 Decatur St.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocarditis, Chr. Secule 422.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Feb 15, 1957 to Oct 15, 1957 that I last saw the deceased alive on Oct 15, 1957 , and that death occurred at 4 P. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE L. B. Matthews M.D.		ADDRESS (Street, city or town, state) 149 Green St	
PHYSICIAN'S NAME (Type) L. B. Matthews M.D. Cumberland, Md.		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 10/18/56	22c. NAME OF CEMETERY OR CREMATORY Mt. Herman Cemetery	22d. LOCATION (City, town, or county) (State) Allegany Co., Maryland
23. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer, Cumberland, Maryland		ADDRESS	
24a. REC'D BY REGISTRAR Oct. 17, 1957		24b. REGISTRAR'S SIGNATURE M. Ross Cameron, M.D. Acting Registrar	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON, 18

BUREAU V. S.

OCT 18 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10121

Reg. Dist. No.

10094

FOR STATE
HEALTH DEPT.

M

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland	c. LENGTH OF STAY IN 1b 3 mo. 3 days	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) x2 LaVale	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Sacred Heart Hospital		d. STREET ADDRESS 554 National Highway	
3. NAME OF DECEASED (Type or print) First Middle Last Laura Virginia Rodenhauser		4. DATE OF DEATH Month Day Year Oct 6 1957	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 29-1875
9. AGE (In years last birthday) 82 yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Cumberland, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles W. Goss		14. MOTHER'S MAIDEN NAME Margaret Main	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. None	
17. INFORMANT (son) John C. Rodenhauser, LaVale, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypostasis of lungs about 12 hrs. 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (b) Arteriosclerotic heart disease ? (a), stating the underlying cause last. 903.0 DUE TO (c) Generalized arteriosclerosis ?			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Intertrochanteric fracture of left femur.			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Vertigo-Standing, turned slightly & fell to the floor.	
20c. TIME OF INJURY Month, Day, Year 5.30 a.m. Aug. 3 1957	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home	20f. (City or town) (County) (State) LaVale Allegany Md.
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE H.V. Deming M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) H.V. Deming M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Oct. 7-1957	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Oct. 9, 1957	22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery	22d. LOCATION (City, town, or county) (State) Cumberland, Md.
23. FUNERAL DIRECTOR'S SIGNATURE H. Wayne George,		ADDRESS Cumberland, Md.	
24a. REC'D BY REGISTRAR Oct. 8, 1957		24b. REGISTRAR'S SIGNATURE W. Ross Cameron, M.D. <i>Acting Registrar</i>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU VI

1957

RECEIVED

10095

CERTIFICATE OF DEATH

Reg. Dist. No.

10122

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND, W				c. LENGTH OF STAY IN 1b 1 DAY			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First EDWARD Middle A. Last SCHADT				4. DATE OF DEATH Month OCTOBER Day 16 Year 19 57			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH MAY 14, 1894	
9. AGE (In years last birthday) 63 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Plumbing Contractor				10b. KIND OF BUSINESS OR INDUSTRY Self		11. BIRTHPLACE (State or foreign country) CUMBERLAND, MD.	
12. CITIZEN OF WHAT COUNTRY? U2 S. A.							
13. FATHER'S NAME SCHADT. PETER				14. MOTHER'S MAIDEN NAME WINDMUTH, LOUISA			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 214-32-2889		17. INFORMANT MEMORIAL HOSPITAL		Address CUMBERLAND, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cirrhosis of Liver 581.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH Unknown
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 9-26-1957 to 10-16-1957 , that I last saw the deceased alive on 10-16-1957 , and that death occurred at 4:45 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Wm. S. Williams M.D.				ADDRESS (Street, city or town, state) Cumberland Md			
DATE SIGNED 10-18-57							
PHYSICIAN'S NAME (Type) DR. W. F. WILLIAMS							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/19/57		22c. NAME OF CEMETERY OR CREMATORY Greenmount Am		22d. LOCATION (City, town, or county) (State) Cumberland Md	
23. FUNERAL DIRECTOR'S SIGNATURE Lee Siles				ADDRESS Cumberland Md		24a. REC'D BY REGISTRAR Oct 19, 1957	
						24b. REGISTRAR'S SIGNATURE W. Ross Cameron, M.D. Acting Registrar	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU A. S.

OCT 22 1957

RECEIVED

10096

CERTIFICATE OF DEATH

Reg. Dist. No.

10123

1. PLACE OF DEATH o. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Barton	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Allegany County Infirmary		d. STREET ADDRESS 1	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Harry Middle Shaw Last Shaw		4. DATE OF DEATH Month October Day 29 Year 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/22/1894
9. AGE (In years last birthday) yrs. 63		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired--Luke Paper Mill-Mining		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (State or foreign country) U. S. A.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Joseph Shaw		14. MOTHER'S MAIDEN NAME Sarah Mains	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT P.O.Box 599 Address Cumberland, Md.		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Sclerosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Chronic Myocarditis (c) General Arteriosclerosis	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH 36 hrs	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 9/4/56 , 19, to 10/28/57 , 19, that I last saw the deceased alive on 10/28/57 , 19, and that death occurred at 4:00A M, from the causes and on the date stated above.			
ACTUAL SIGNATURE James E. McLean M.D.		ADDRESS (Street, city or town, state) 49 Greene St. DATE SIGNED 10/29/57	
PHYSICIAN'S NAME (Type) Dr. James E. McLean		Cumberland, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Nov. 1, 1957	22c. NAME OF CEMETERY OR CREMATORY Laurel Hill Cemetery	22d. LOCATION (City, town, or county) (State) Moscow, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Boal's Funeral Home, Westernport, Maryland.		24. REGISTRAR'S SIGNATURE W. Ross Cameron, M.D. <i>Acting Registrar</i>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 and 5 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 4 and 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

10:21 AM

2. 1000

0.22

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- 1 -

82-258-10-271

BUREAU V. S.

NOV 4 1957

RECEIVED

10097

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 22 Frostburg	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Allegany County Infirmary		d. STREET ADDRESS 73 W. Main Street	
3. NAME OF DECEASED (Type or print) First J. Middle William Last Shea		4. DATE OF DEATH Month October Day 10 , Year 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/20/1874
9. AGE (In years last birthday) yrs. 82		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired-Memorial Hospital Pharmacist		10b. KIND OF BUSINESS OR INDUSTRY Frostburg, Maryland	
11. BIRTHPLACE (State or foreign country) U. S. A.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Michael Shea		14. MOTHER'S MAIDEN NAME Catherine Powers	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 212-10-6242	
17. INFORMANT P.O. Box 599 Allegany County Infirmary Records		Address Cumberland, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic Myocarditis DUE TO (c) Cerebral Arteriosclerosis			INTERVAL BETWEEN ONSET AND DEATH Sudden
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Senile Deterioration			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 9/26/57 , 19____, to 10/10/57 , 19____, that I last saw the deceased alive on 10/9/57 , 19____, and that death occurred at 3:20A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 49 Greene St. DATE SIGNED 10/10/57			
ACTUAL SIGNATURE Dr. J. E. McLean M.D.		DATE SIGNED 10/10/57	
PHYSICIAN'S NAME (Type) Dr. J. E. McLean		Cumberland, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 10-12-57	22c. NAME OF CEMETERY OR CREMATORY St. Michael's Cemetery	22d. LOCATION (City, town, or county) (State) Frostburg, Md.
23. FUNERAL DIRECTOR'S SIGNATURE J. R. Durst,		ADDRESS Frostburg, Md.	
24a. REC'D BY REGISTRAR Oct 12, 1957		24b. REGISTRAR'S SIGNATURE W. Ross Cameron M.D. <i>Acting Registrar</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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CERTIFICATE OF DEATH

Allegany

Allegany

Allegany

Prosser

9/25/57

Allegany

73 W. Main Street

Allegany County Infirmary

Shen

William

1.

October 10, 1957

11/20/1875

Male White

Baltimore Memorial Hospital, Baltimore, Maryland U. S. A.

Catherine Powers

Michael Shen

Allegany County Infirmary Records

BUREAU V. 2

OCT 15 1957

RECEIVED

10098

CERTIFICATE OF DEATH

Reg. Dist. No.

4

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland				c. LENGTH OF STAY IN 1b 11/23/49			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Allegany County Infirmary				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Anna Middle Viola Last Slemmer				4. DATE OF DEATH Month October Day 12 Year 1957			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug 9 1875	
9. AGE (In years last birthday) 82 yrs.		IF UNDER 1 YEAR Months 82 Days 82 Hours 82 Min. 82		IF UNDER 24 HRS. Months 82 Days 82 Hours 82 Min. 82			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY House		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME Charles C. Hetzel				14. MOTHER'S MAIDEN NAME Margaret James			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No				16. SOCIAL SECURITY NO. None		17. INFORMANT P.O. Box 599 Address Cumberland, Md. Allegany County Infirmary Records	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Hypostasis 422.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic Myocarditis DUE TO (c) Cerebral Arteriosclerosis INTERVAL BETWEEN ONSET AND DEATH 10 days ? ?							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cerebral Hemorrhage 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month. Day. Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 11/23/49 , 19____, to 10/12/57 , 19____, that I last saw the deceased alive on 10/12/57 , 19____, and that death occurred at 2:00A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 49 Green St. Cumberland, Md. DATE SIGNED 10/12/57							
ACTUAL SIGNATURE Dr. J. E. McLean				PHYSICIAN'S NAME (Type) Dr. J. E. McLean			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF Oct 15 1957		22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery	
22d. LOCATION (City, town, or county) (State) Cumberland Md							
23. FUNERAL DIRECTOR'S SIGNATURE William H. Kight				ADDRESS Cumberland, Md.		24. REC'D BY REGISTRAR Oct 12, 1957	
24b. REGISTRAR'S SIGNATURE W. Ross Cameron M.D. Acting Registrar							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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gamma

Refresher

October 14, 1951

• **transit**

BUREAU V. S.

OCT 17 1957

RECEIVED

Dr. J. J. ...

10123

CERTIFICATE OF DEATH

10126

Reg. Dist. No. 9

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg				c. LENGTH OF STAY IN 1b 2 weeks			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Miner's Hospital				d. STREET ADDRESS x2 R.D.1, Frostburg,		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Frank Middle E. Last Smith				4. DATE OF DEATH Month Oct. Day 30th , Year 19 57			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct. 7th, 1881	
9. AGE (In years lost birthday) 76 yrs.		IF UNDER 1 YEAR Months 76 Days 76 Hours 76 Min. 76		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret.-Curing Dept. Tire Company.		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME Luther Smith			
14. MOTHER'S MAIDEN NAME Rose Ann Drum				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) 214-07-085			
16. SOCIAL SECURITY NO. 214-07-085				17. INFORMANT Mrs. Loretta Leonard, R.D.1, Frostburg, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Infarction DUE TO 420.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Atherosclerotic Heart Dis. (c) Sclerosis, Prostatitis + Uremia							INTERVAL BETWEEN ONSET AND DEATH 1 to 15
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 491X Bronchopneumonia							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Frostburg, Md.				20g. (State) Md.			
21. I certify that I attended the deceased from OCT 29, 1957 to OCT 30, 1957 , that I last saw the deceased alive on OCT 29, 1957 , and that death occurred at 5 P.M. from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) 134 E Main				DATE SIGNED 11/1/57			
ACTUAL SIGNATURE John C. Durst				M.D. Frostburg, Md.			
PHYSICIAN'S NAME (Type) John C. Durst							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-2-57		22c. NAME OF CEMETERY OR CREMATORY St. Michael's Cemetery		22d. LOCATION (City, town, or county) (State) Frostburg, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Joseph R. Durst,				ADDRESS Frostburg, Md.		24a. REC'D BY REGISTRAR DATE 11-2-57	
				24b. REGISTRAR'S SIGNATURE Mrs. Nancy H. Rose			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. 5

NOV 12 1957

RECEIVED

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10127

10124

CERTIFICATE OF DEATH

Reg. Dist. No.

9

1. PLACE OF DEATH o. COUNTY <u>Allegany</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frostburg</u>	c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frostburg</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Miners Hospital</u>	d. STREET ADDRESS <u>X2 Lonaconing</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Baby</u> Middle <u>Steele</u> Last <u>Steele</u>		4. DATE OF DEATH Month <u>October</u> Day <u>31</u> Year <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10/28/57</u>
9. AGE (In years lost birthday) yrs. <u>2</u>		IF UNDER 1 YEAR Months <u>2</u> Days <u>2</u> Hours <u>2</u> Min. <u>2</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Frostburg Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Calvin Steele</u>		14. MOTHER'S MAIDEN NAME <u>Ruth Brinegar</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Calvin Steele Lonaconing Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumatury</u> 776X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>(birth wt. 2 lb.)</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>OCT 28, 1957</u> , to <u>OCT 31, 1957</u> , that I last saw the deceased alive on <u>OCT 29, 1957</u> , and that death occurred at <u>M</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>John C. Pappas</u> M.D.		ADDRESS (Street, city or town, state) <u>Frostburg Md</u> DATE SIGNED <u>10/31/57</u>	
PHYSICIAN'S NAME (Type) <u>John C. Pappas</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>10/31/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Memorial Park</u>	22d. LOCATION (City, town, or county) (State) <u>Frostburg Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>George Eichhorn Lonaconing Md.</u>		ADDRESS <u>2061243XVO</u>	
24a. REC'D BY REGISTRAR <u>11-1-57</u>		24b. REGISTRAR'S SIGNATURE <u>Mrs. Nancy W. Rice</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 7 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10125

Items 8,9 Film G222 11-4-57 et

CERTIFICATE OF DEATH

10128

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg		c. LENGTH OF STAY IN IB 1 day	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 22 Frostburg		d. STREET ADDRESS 28 E. College Avenue	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Miners Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First JOHN Middle J. Last SULLIVAN		4. DATE OF DEATH Month 10 Day 17 Year 1957	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 11, 1878
9. AGE (In years last birthday) 79 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Forman		10b. KIND OF BUSINESS OR INDUSTRY Construction	
11. BIRTHPLACE (State or foreign country) Barton, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John O. Sullivan		14. MOTHER'S MAIDEN NAME Catherine Ryan	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Wm. Sullivan, 29 McCulloh St., Frostburg Md.		Address (Son)	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertensive Cardio-vascular disease 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary sclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Totally blind.		INTERVAL BETWEEN ONSET AND DEATH 10 years. 5 years.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 7-10, 1947 to 10-17, 1957 , that I last saw the deceased alive on 10-17, 1957 , and that death occurred at 1145 P.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE H.C. Diehl		ADDRESS (Street, city or town, state) DATE SIGNED 39 W. MAIN, ST. 10/18/57	
PHYSICIAN'S NAME (Type) H.C. Diehl, M.D.		Frostburg, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10-19-57	
22c. NAME OF CEMETERY OR CREMATORY St. Michael's Cemetery		22d. LOCATION (City, town, or county) (State) Frostburg Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Hafer Funeral Home		24a. REC'D BY REGISTRAR 23 E. Main, Frostburg, Md.	
24b. REGISTRAR'S SIGNATURE DATE 10-21-57			

10099

CERTIFICATE OF DEATH

Reg. Dist. No.

4

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE WEST VIRGINIA b. COUNTY GRANT			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) PETERSBURG 85X-3			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL				d. STREET ADDRESS 15 E. AVENUE			
3. NAME OF DECEASED (Type or print) First Middle Last IDA FLORENCE SWICK				4. DATE OF DEATH Month Day Year OCTOBER 4 1957			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH SEPT. 7, 1873	
9. AGE (In years last birthday) 84 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE				10b. KIND OF BUSINESS OR INDUSTRY OWN HOME		11. BIRTHPLACE (State or foreign country) WEST VIRGINIA	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME ISAAC LEWIS				14. MOTHER'S MAIDEN NAME CATHERINE THORN			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) If yes, give war or dates of service NO				16. SOCIAL SECURITY NO. NONE		17. INFORMANT Address MEMORIAL HOSPITAL	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Terminal Arterial Failure 420.0 DUE TO arteriosclerotic Heart Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized arteriosclerosis (c) Generalized arteriosclerosis INTERVAL BETWEEN ONSET AND DEATH 5 days 5 years 7							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 3 Oct. 1957 to 4 Oct. 1957 , that I last saw the deceased alive on 4 Oct. 1957 , and that death occurred at 4.00 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 1225 S. Centre St. Cumberland, Md. DATE SIGNED 5 Oct. 57							
ACTUAL SIGNATURE W. A. Van Ormer M.D.							
PHYSICIAN'S NAME (Type) DR. W. A. VAN ORMER							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct. 6, 1957		22c. NAME OF CEMETERY OR CREMATORY North Mill Creek Cemetery		22d. LOCATION (City, town, or county) (State) Grant County, West Virginia.	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS J. Blaine Schaffer Petersburg, Va.				24a. REC'D BY REGISTRAR Oct. 5, 1957		24b. REGISTRAR'S SIGNATURE W. Ross Cameron, M.D. Acting Registrar	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 15

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH	
FLORENCE MCK		40		F		W		1917	
PLACE OF BIRTH		DATE OF DEATH		TIME OF DEATH		CAUSE OF DEATH		MANNER OF DEATH	
BALTIMORE, MARYLAND		OCT 8 1957		10:00 AM		HEART DISEASE		NATURAL	
OCCUPATION		EDUCATION		MARRIAGE		SINGLE		MARRIED	
HOUSEWIFE		HIGH SCHOOL		YES		YES		YES	
PREVIOUS ILLNESS		PREVIOUS SURGERY		PREVIOUS TRAUMA		PREVIOUS DRUGS		PREVIOUS ALCOHOL	
NONE		NONE		NONE		NONE		NONE	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR		SIGNATURE OF WITNESS		SIGNATURE OF DECEASED		SIGNATURE OF NEXT OF KIN	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	

BUREAU V. S.

OCT 8 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 could be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10100

CERTIFICATE OF DEATH

10130

Reg. Dist. No. 4

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE WEST VIRGINIA b. COUNTY MINERAL	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 6 DAYS	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ✓ SPRINGFIELD 85X-3		d. NAME OF HOSPITAL (If not in hospital, give street address) MEMORIAL HOSPITAL	
d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First BRUCE Middle WILDE Last WY BRUCE SWISHER		4. DATE OF DEATH Month OCTOBER Day 14 Year 19 57.	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH FEBRUARY 26, 1884
9. AGE (In years last birthday) 73 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Own Farm	
11. BIRTHPLACE (State or foreign country) WEST VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME SAMUEL SWISHER		14. MOTHER'S MAIDEN NAME REBECCA LANNAN	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 234-68-0878	
17. INFORMANT MEMORIAL HOSPITAL - CUMBERLAND, MD.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hemorrhagic Pericarditis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cerebral Hemorrhage INTERVAL BETWEEN ONSET AND DEATH Immediate			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. City or town (County) (State) Cumberland City, Md.	
21. I certify that I attended the deceased from 10/18/57 19, to 10/14/57 19, that I last saw the deceased alive on 10/14/57 19, and that death occurred at 9:15 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Cumberland, Md. DATE SIGNED 10/14/57 ACTUAL SIGNATURE Richard J. Williams PHYSICIAN'S NAME (Type) DR. RICHARD J. WILLIAMS			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF October 17, 57	
22c. NAME OF CEMETERY OR CREMATORY Methodist		22d. LOCATION (City, town, or county) (State) Three Churches	
23. FUNERAL DIRECTOR'S SIGNATURE W. A. Meku		24a. REG'D BY REGISTRAR DATE Oct. 16, 1957	
24b. REGISTRAR'S SIGNATURE W. Ross Cameron, M.D.			

RECEIVED

10101

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland				c. LENGTH OF STAY IN 1b 40 years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1316 Virginia Ave.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First IRA Middle ELLIS Last TEETS				4. DATE OF DEATH Month Oct. Day 31 Year 1957			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 23, 1878		9. AGE (In years lost birthday) 79 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Rubber worker		10b. KIND OF BUSINESS OR INDUSTRY Tire industry		11. BIRTHPLACE (State or foreign country) Friendsville, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Silas Teets				14. MOTHER'S MAIDEN NAME Sarah Shroyer			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 217-10 7217		17. INFORMANT Address Chancy R. Teets, Cumberland, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 152x DUE TO Carcinoma Small Intestine Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 180 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from October 31, 1957 to October 31, 1957 , that I last saw the deceased alive on October 31, 1957 , and that death occurred at 5:45 PM from the causes and on the date stated above.							
ACTUAL SIGNATURE E. E. Broadbent				DATE SIGNED 200 Virginia Avenue			
PHYSICIAN'S NAME (Type) E. E. Broadbent				Cumberland, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/2/1957		22c. NAME OF CEMETERY OR CREMATORY Hill Crest Cemetery		22d. LOCATION (City, town, or county) (State) Cumberland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Byron Kight				ADDRESS Cumberland, Md.		24a. REC'D BY REGISTRAR W. Ross Cameron M.D.	
				24b. REGISTRAR'S SIGNATURE Acting Registrar			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. Name of deceased		2. Sex		3. Age		4. Date of death		5. Place of death	
6. Cause of death		7. Nature of disease		8. Duration of illness		9. Name of physician		10. Name of attending nurse	
11. Name of informant		12. Signature of informant		13. Signature of physician		14. Signature of attending nurse		15. Signature of registrar	
16. Name of registrar		17. Signature of registrar		18. Signature of registrar		19. Signature of registrar		20. Signature of registrar	
21. Name of registrar		22. Signature of registrar		23. Signature of registrar		24. Signature of registrar		25. Signature of registrar	
26. Name of registrar		27. Signature of registrar		28. Signature of registrar		29. Signature of registrar		30. Signature of registrar	
31. Name of registrar		32. Signature of registrar		33. Signature of registrar		34. Signature of registrar		35. Signature of registrar	
36. Name of registrar		37. Signature of registrar		38. Signature of registrar		39. Signature of registrar		40. Signature of registrar	
41. Name of registrar		42. Signature of registrar		43. Signature of registrar		44. Signature of registrar		45. Signature of registrar	
46. Name of registrar		47. Signature of registrar		48. Signature of registrar		49. Signature of registrar		50. Signature of registrar	
51. Name of registrar		52. Signature of registrar		53. Signature of registrar		54. Signature of registrar		55. Signature of registrar	
56. Name of registrar		57. Signature of registrar		58. Signature of registrar		59. Signature of registrar		60. Signature of registrar	
61. Name of registrar		62. Signature of registrar		63. Signature of registrar		64. Signature of registrar		65. Signature of registrar	
66. Name of registrar		67. Signature of registrar		68. Signature of registrar		69. Signature of registrar		70. Signature of registrar	
71. Name of registrar		72. Signature of registrar		73. Signature of registrar		74. Signature of registrar		75. Signature of registrar	
76. Name of registrar		77. Signature of registrar		78. Signature of registrar		79. Signature of registrar		80. Signature of registrar	
81. Name of registrar		82. Signature of registrar		83. Signature of registrar		84. Signature of registrar		85. Signature of registrar	
86. Name of registrar		87. Signature of registrar		88. Signature of registrar		89. Signature of registrar		90. Signature of registrar	
91. Name of registrar		92. Signature of registrar		93. Signature of registrar		94. Signature of registrar		95. Signature of registrar	
96. Name of registrar		97. Signature of registrar		98. Signature of registrar		99. Signature of registrar		100. Signature of registrar	

BUREAU V. S.

NOV 4 1931

RECEIVED

10102

CERTIFICATE OF DEATH

Reg. Dist. No.

4

1. PLACE OF DEATH a. COUNTY ALLEGANY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE WEST VIRGINIA b. COUNTY MINERAL			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND, MD.				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) KEYSER, W. VA.			
c. LENGTH OF STAY IN 1b 3 DAYS				d. STREET ADDRESS 25 MAPLE AVE.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) EARL		First RAYMOND		Middle TRENTON		Last	
4. DATE OF DEATH Month OCTOBER		Day 12		Year 1957			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH NOV. 21, 1886	
9. AGE (In years last birthday) 70		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Filter Plant Operator-Retired B. & O. R.R. Co.				10b. KIND OF BUSINESS OR INDUSTRY PENNSYLVANIA		11. BIRTHPLACE (State or foreign country) U. S. AMERICA	
12. CITIZEN OF WHAT COUNTRY? U. S. AMERICA							
13. FATHER'S NAME JACOB L. TRENTON				14. MOTHER'S MAIDEN NAME MARY HARDEN			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 705-05-1681		17. INFORMANT MEMORIAL HOSPITAL		Address CUMBERLAND, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Pneumonitis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Silicosis DUE TO (c) Hypertension, General arteriosclerosis							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from Oct 9 , 19 57 , to Oct 12 , 19 57 , that I last saw the deceased alive on Oct 12 , 19 57 , and that death occurred at 6:15 P M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Cumberland, Maryland DATE SIGNED 10/15/57							
ACTUAL SIGNATURE Leslie E. Daugherty				M.D. Cumberland, Maryland			
PHYSICIAN'S NAME (Type) DR. L. E. DAUGHERTY							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct. 15, 1957		22c. NAME OF CEMETERY OR CREMATORY Queen's Point Cemetery		22d. LOCATION (City, town, or county) (State) Keyser, West Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE B. W. Markwood				24. REC'D BY REGISTRAR W. Ross Cameron, M.D. 24b. REGISTRAR'S SIGNATURE Acting Registrar			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

NAME OF DECEASED JOHN A. SMITH		DATE OF BIRTH JAN 15 1900		PLACE OF BIRTH BALTIMORE, MD	
MARRIAGE MARRIED		DATE OF MARRIAGE JUN 15 1925		PLACE OF MARRIAGE BALTIMORE, MD	
OCCUPATION LABORER		DATE OF DEATH OCT 10 1957		PLACE OF DEATH BALTIMORE, MD	
CAUSE OF DEATH HEART DISEASE		MANNER OF DEATH NATURAL		CERTIFICATE NO. 12345	
SIGNATURE OF PHYSICIAN J. E. SMITH		SIGNATURE OF REGISTRAR J. E. SMITH		SIGNATURE OF DECEASED JOHN A. SMITH	
DATE OF SIGNATURE OCT 10 1957		DATE OF SIGNATURE OCT 10 1957		DATE OF SIGNATURE OCT 10 1957	

BUREAU FILE

OCT 17 1957

RECEIVED

1
Within corporate limits
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
10103 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10133
4

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Allegany</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>		c. LENGTH OF STAY IN lb <u>20 years</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>215 Green St.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Lorenzo</u> Middle <u>Elwood</u> Last <u>VanSant</u>		4. DATE OF DEATH Month <u>Oct</u> Day <u>23</u> Year <u>19 57</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 15 1884</u>
9. AGE (In years last birthday) <u>76</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Prop. Publicity Agency</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Publicity Business</u>	
11. BIRTHPLACE (State or foreign country) <u>Cumberland, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Theodore VanSant</u>		14. MOTHER'S MAIDEN NAME <u>Virginia Lee</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>212-18-1332</u>	
17. INFORMANT <u>(daughter) Mrs. Chester Evans</u>		Address <u>Cumberland Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Coronary sclerosis</u> DUE TO (c) <u>Arteriosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u> <u>?</u> <u>?</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a. m. <u> </u> p. m. <u> </u> 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>H. V. Deming</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>H. V. Deming M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>Oct. 24-1957</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>10/26/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Hillcrest Burial Park</u>	22d. LOCATION (City, town, or county) (State) <u>Cumberland, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles L. George</u>		ADDRESS <u>Cumberland, Md.</u>	
24a. REC'D BY REGISTRAR <u>Oct. 26, 1957</u>		24b. REGISTRAR'S SIGNATURE <u>W. Ross Cameron, M.D.</u> <u>Acting Registrar</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF
HEALTH

MARYLAND STATE DEPARTMENT OF HEALTH—Baltimore, Md.
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. 3

OCT 29 1957

RECEIVED

10147

CERTIFICATE OF DEATH

10134

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Route 2, Frostburg				c. LENGTH OF STAY IN 1b 60 yrs.			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Route 2, Frostburg, x2				d. STREET ADDRESS 1			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Nicola Middle Via Last Via				4. DATE OF DEATH Month Oct. Day 25th , Year 19 57			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 13th, 1873		9. AGE (In years last birthday) 84 yrs.	IF UNDER 1 YEAR Months 84 Days 84 Hours 84 Min. 84	IF UNDER 24 HRS. Months 84 Days 84 Hours 84 Min. 84
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Miner				10b. KIND OF BUSINESS OR INDUSTRY Coal Mining		11. BIRTHPLACE (State or foreign country) Italy	
13. FATHER'S NAME Vincent Via				14. MOTHER'S MAIDEN NAME Teresina Rosanova			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. 216-03-4325			
17. INFORMANT Mrs. Marie Via, Box 117, Route 2, Frostburg, Md.				18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Silicosis DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Silicosis			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Frostburg, Md.				20g. (County) Frostburg, Md.			
20h. (State) Frostburg, Md.				20i. (Country) Frostburg, Md.			
21. I certify that I attended the deceased from June 8 , 19 56 , to Oct. 25 , 19 57 , that I last saw the deceased alive on Oct. 25 , 19 57 , and that death occurred at 11:05 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Martin M. Rothstein, M.D.				ADDRESS (Street, city or town, state) 48 Broadway			
DATE SIGNED 10/25/57				DATE SIGNED 10/25/57			
PHYSICIAN'S NAME (Type) Martin M. Rothstein, M.D.				Frostburg, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10-28-57		22c. NAME OF CEMETERY OR CREMATORY St. Michael's Cemetery		22d. LOCATION (City, town, or county) (State) Frostburg, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Joseph R. Durst				ADDRESS Frostburg, Md.		24a. REC'D BY REGISTRAR 10-26-57	
24b. REGISTRAR'S SIGNATURE Mrs. Nancy N. Re				24c. REGISTRAR'S SIGNATURE Mrs. Nancy N. Re			

BUREAU V. S.

OCT 28 1957

RECEIVED

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10135

10104

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 4

FOR STATE HEALTH DEPT.

M

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11

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Allegany</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>		c. LENGTH OF STAY IN 1b <u>71 yrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>02 Cumberland</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>137 Maple St.</u>			d. STREET ADDRESS <u>137 Maple St.</u>		
3. NAME OF DECEASED (Type or print) First <u>Anna</u> Middle <u>Beth</u> Last <u>Wagner</u>			4. DATE OF DEATH Month <u>Oct.</u> Day <u>12</u> Year <u>19 57</u>		
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 6-1886</u>	9. AGE (In years last birthday) <u>71</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Cumberland, Md.</u>	
13. FATHER'S NAME <u>John Reuschal</u>			14. MOTHER'S MAIDEN NAME <u>Anna Hartung</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Memorial Hospital old records. Wm. J. Creegan, Cumberland, Md. &</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Congestive heart failure</u> DUE TO heart (b) <u>Arteriosclerotic cardio-vascular disease</u> DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u> <u>?</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)	19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>H. V. Deming M.D.</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <u>H. V. Deming M.D.</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		<u>Oct. 15-1957</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Oct. 17, 1957</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Hillcrest Burial Park</u>	22d. LOCATION (City, town, or county) <u>Cumberland, Maryland</u>	(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hafer Funeral Home, Cumberland, Maryland.</u>			24a. REC'D BY REGISTRAR <u>Oct. 16, 1957</u>	24b. REGISTRAR'S SIGNATURE <u>W. Ross Cameron, M.D. Acting Registrar</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

OCT 17 1957

BUREAU V. S.

RECEIVED
FEDERAL BUREAU OF INVESTIGATION
U. S. DEPARTMENT OF JUSTICE

MAYLAND STATE DEPARTMENT OF HEALTH - LABORATORY
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10126

CERTIFICATE OF DEATH

Reg. Dist. No.

9

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg				c. LENGTH OF STAY IN 1b 1 week			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Miners Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last PAUL LOUIS WALBERT				4. DATE OF DEATH Month Day Year October 28, 1957 19			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 18, 1902	9. AGE (In years last birthday) yrs. 54	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Celanese Corporation		11. BIRTHPLACE (State or foreign country) Frostburg, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Louis Walbert				14. MOTHER'S MAIDEN NAME Diana Richards			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) 215-10-4451		17. INFORMANT New Row Mrs. Virgie Walbert Mt. Savage, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Infarction 492x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Pneumonia & Effusion DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 6 hrs 14 days							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) RECURRENT BRONCHIAL ASTHMA							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) New Row	
20f. (City or town) New Row				20g. (County) Allegany		20h. (State) Md.	
21. I certify that I attended the deceased from OCT. 21, 1957 , to OCT. 28, 1957 , that I last saw the deceased alive on OCT. 28, 1957 , and that death occurred at 2:45 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 48 Broadway, Frostburg, Md. DATE SIGNED John J. Hafer							
ACTUAL SIGNATURE John J. Hafer M.D.							
PHYSICIAN'S NAME (Type) Martin M. Rothstein M.D. 48 Broadway, Frostburg, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/30/57		22c. NAME OF CEMETERY OR CREMATORY Frostburg Memorial Park		22d. LOCATION (City, town, or county) (State) Frostburg, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer, Cumberland, Maryland				24a. REC'D BY REGISTRAR 10-30-57		24b. REGISTRAR'S SIGNATURE Mrs. Mary N. Rice	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

NOV 5 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

DR. BALLIN

10105

CERTIFICATE OF DEATH

10137
Reg. Dist. No. 4

1. PLACE OF DEATH o. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. LENGTH OF STAY IN 1b 44 DAYS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First MARGARET Middle E. Last WILLISON				4. DATE OF DEATH Month OCTOBER Day 18 Year 19 57			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH JANUARY 30, 1904	
9. AGE (In years last birthday) 53 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE				10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME GEORGE GRIFFITH				14. MOTHER'S MAIDEN NAME ANN FARRADAY			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no, or unknown) No (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT MEMORIAL HOSPITAL - CUMBERLAND, MD.				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ca of pancreas 157x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 9-15 , 19 56 , to 10-18 , 19 57 , that I last saw the deceased alive on 10-18 , 19 57 , and that death occurred at 1:05 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 62 Greene St. DATE SIGNED 10-18-57							
ACTUAL SIGNATURE R. Ballin				M.D. Cumberland, Md.			
PHYSICIAN'S NAME (Type) DR. R. BALLIN							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/20/57		22c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park		22d. LOCATION (City, town, or county) (State) Cumberland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer				ADDRESS Cumberland, Maryland		24a. REC'D BY REGISTRAR Oct. 19, 1957	
				24b. REGISTRAR'S SIGNATURE W. Ross Cameron, M.D.		Acting Registrar	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

STATE OF NEW YORK

DATE OF DEATH

ALL

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21 DAYS

NEUTRAL HOSPITAL

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GEORGE W. WHITE

NEUTRAL HOSPITAL - DUNELAND, N.Y.

BUREAU V. S.

OCT 22 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10138

10106

CERTIFICATE OF DEATH

Reg. Dist. No.

4

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>				c. LENGTH OF STAY IN 1b <u>20 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X2 Cumberland</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Sacred Heart Hospital</u>				d. STREET ADDRESS <u>1 Rt. #2, Mt. Pleasant Rd.</u>			e. 15 RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>Randolph</u> Middle <u>Wilson</u> Last <u>Wilson</u>				4. DATE OF DEATH Month <u>10/</u> Day <u>30</u> Year <u>19 57</u>					
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3/17/86</u>			
9. AGE (In years last birthday) <u>71</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Rubber Worker</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Kelly</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>			
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>Normal Wilson</u>					
14. MOTHER'S MAIDEN NAME <u>Margaret McCulley Wilson</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)					
16. SOCIAL SECURITY NO. <u>715-70 6493</u>				17. INFORMANT <u>Pt's chart</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> <u>491 X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Parkinson's disease</u>								INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)								20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month <u> </u> Day <u> </u> Year <u>19 57</u> Hour a. m. <u> </u> p. m. <u> </u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town)				20g. (County)		20h. (State)			
21. I certify that I attended the deceased from <u>Oct 9</u> , 19 <u>57</u> , to <u>Oct 30</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Oct 29</u> , 19 <u>57</u> , and that death occurred at <u>1:20 a.m.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Cumberland, Md 220 Baltimore Ave</u> DATE SIGNED <u>10/30/57</u>									
ACTUAL SIGNATURE <u>R. W. Trevas, Sr.</u> M.D. <u>Cumberland, Md</u>									
PHYSICIAN'S NAME (Type) <u>R. W. TREVAS, SR</u> <u>Cumberland, Maryland</u>									
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11/1/1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Zion Memorial Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Cumberland, Md.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Byron Kight, Cumberland, Md.</u>				24a. REC'D BY REGISTRAR <u>Oct 31, 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Ed. Ross Cameron, M.D.</u> <u>Acting Registrar</u>			

CERTIFICATE OF DEATH

NAME OF DECEASED: [illegible]
 SEX: [illegible] AGE: [illegible]
 DATE OF BIRTH: [illegible]
 PLACE OF BIRTH: [illegible]
 OCCUPATION: [illegible]
 CAUSE OF DEATH: [illegible]
 PLACE OF DEATH: [illegible]
 TIME OF DEATH: [illegible]
 SIGNATURE OF PHYSICIAN: [illegible]
 SIGNATURE OF REGISTRAR: [illegible]

BUREAU V. S.

NOV 1 1951

RECEIVED

DR. LEY

10107

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LA VALE	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL		d. STREET ADDRESS 337 NATIONAL HIGHWAY	
3. NAME OF DECEASED (Type or print) First ANNA Middle — Last STASIA WINTERMYER		4. DATE OF DEATH Month OCTOBER Day 31 Year 1957	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH OCT. 9, 1888
9. AGE (In years last birthday) 69 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED		10b. KIND OF BUSINESS OR INDUSTRY Colonese Inc.	
11. BIRTHPLACE (State or foreign country) CUMBERLAND, MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOHN J. WINTERMYER		14. MOTHER'S MAIDEN NAME MARY ELLEN LAVIN	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, and of unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. —	
17. INFORMANT MEMORIAL HOSPITAL - CUMBERLAND, MD.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____ DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 10/30 , 19 57 , to 10/31 , 19 57 , that I last saw the deceased alive on 10/30 , 19 57 , and that death occurred at 5:15 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 456 N. Centre St. DATE SIGNED 10/31/57 ACTUAL SIGNATURE Leo J. Ley Jr. M.D. PHYSICIAN'S NAME (Type) DR. LEO LEY Cumberland, Ind.			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
Buried	Nov. 2, 1957	St. Peter & Pauls	Cumberland, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Louis Stein Inc.		24a. REC'D BY REGISTRAR Nov. 2, 1957	
ADDRESS Cumb Md		24b. REGISTRAR'S SIGNATURE W. Ross Cameron M.D. Acting Registrar	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

ALLEGEDLY

UNKNOWN

UNKNOWN

UNKNOWN

11 YEAR

1 DAY

GENERAL HOSPITAL

321 NATIONAL HIGHWAY

ADMIN - STASIA WINTERBURY

ALL WHITE

MARY ELLEN LAYNE

JOHN J. WINTERBURY

GENERAL HOSPITAL - CHICAGO

BUREAU V. S.

NOV 6 1971

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10140

10127

CERTIFICATE OF DEATH

Reg. Dist. No.

9

1. PLACE OF DEATH o. COUNTY <u>Allegany</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Allegany</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frostburg</u>			c. LENGTH OF STAY IN 1b <u>Lifetime</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frostburg 22</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>170 Maple Street</u>				d. STREET ADDRESS <u>170 Maple St.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Elizabeth Miller Workman</u>				4. DATE OF DEATH Month Day Year <u>10 17 1957</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 7, 1871</u>		9. AGE (In years last birthday) <u>86</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Frostburg, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George Miller</u>				14. MOTHER'S MAIDEN NAME <u>Anna Sorg</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>Miss Elizabeth Workman, 170 Maple St., Frostburg, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>422.1</u> <u>Artemia</u> DUE TO (b) <u>Cardiovascular disease</u> DUE TO (c) <u>years-</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.						INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>March, 1957</u> to <u>October 1957</u> , that I last saw the deceased alive on <u>October 19, 1957</u> , and that death occurred at <u>2:15 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>2 Broadway, Frostburg, Md.</u> DATE SIGNED <u>10/18/57</u>							
ACTUAL SIGNATURE <u>John B. Davis, M.D.</u>		PHYSICIAN'S NAME (Type) <u>John B. Davis, M.D.</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10-20-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Frostburg Memorial Park Frostburg</u>		22d. LOCATION (City, town, or county) (State) <u>Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>B.H. Montecant</u>				24a. REC'D BY REGISTRAR <u>23 E. Main, Frostburg, Md.</u>		24b. REGISTRAR'S SIGNATURE <u>Miss Nancy N. R...</u>	

BUREAU V. S.

OCT 23 1957

RECEIVED

With corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10141

DR. W.F. WILLIAMS

10108

CERTIFICATE OF DEATH

Reg. Dist. No.

4

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE WEST VIRGINIA b. COUNTY MINERAL			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. LENGTH OF STAY IN 1b 1 DAY		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) KEYSER 85 x -3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL				d. STREET ADDRESS 138 D. STREET			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First WILLIAM Middle LEROY Last WOY				4. DATE OF DEATH Month OCTOBER Day 12 Year 19 57			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH JULY 10, 1912		9. AGE (In years last birthday) 45	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PIPEFITTER		10b. KIND OF BUSINESS OR INDUSTRY W.VA. PULP & PAPER		11. BIRTHPLACE (State or foreign country) CUMBERLAND, MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME EARL C. WOY				14. MOTHER'S MAIDEN NAME RACHEL GROSS			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) W.W.II		16. SOCIAL SECURITY NO.		17. INFORMANT MEMORIAL HOSPITAL - CUMBERLAND, MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 12 hours							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 10-12-1957 to 10-12-1957 that I last saw the deceased alive on 10-12-1957 , and that death occurred at 11:30 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Cumberland Md DATE SIGNED 10-13-57							
ACTUAL SIGNATURE Dr. W.F. Williams		PHYSICIAN'S NAME (Type) DR. W.F. WILLIAMS					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct. 15, 1957		22c. NAME OF CEMETERY OR CREMATORY Philos Cemetery		22d. LOCATION (City, town, or county) (State) Westernport, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Rogers Funeral Home, Keyser, West Virginia.				24a. REC'D BY REGISTRAR Oct. 14, 1957		24b. REGISTRAR'S SIGNATURE W. Ross Cameron, M.D. Acting Registrar	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

DR. W. V. WILKINS

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

1957 OCT 15

DEATH

DATE

1957 OCT 15

TIME

10:00 AM

PLACE

GENERAL HOSPITAL

1234 STREET

1957 OCT 15

WILKINS

WILKINS

WILKINS

WILKINS

WILKINS

WILKINS

WILKINS

WILKINS

GENERAL HOSPITAL - BALTIMORE, MD.

BUREAU V. 8

OCT 15 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10142

10128

CERTIFICATE OF DEATH

Reg. Dist. No.

9

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) National "Rural" Frostburg	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Miners Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Bessie Middle Elmira Last Yantz		4. DATE OF DEATH Month October Day 8 Year 19 57	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH December 20, 1890
9. AGE (In years lost birthday) 67 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Mt Savage Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Yantz		14. MOTHER'S MAIDEN NAME Julia Tayler	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	
17. INFORMANT Margaret Yantz		Address National, Md	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Extreme Cachexia and Anemia DUE TO (b) Carcinomatosis COUSE (c), stating the underlying cause last. (c) Carcinoma of Recto-Sigmoid INTERVAL BETWEEN ONSET AND DEATH 30 d. ? 4 mos. ? 10 mos.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from March 28, 1927 to 10 8 157 , that I last saw the deceased alive on 10 18 , 19 57 , and that death occurred at 2:40 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Frank T. Harriet		ADDRESS (Street, city or town, state) 26 W. Mechanic St. Frostburg Md.	
PHYSICIAN'S NAME (Type) FRANK T. HARRAT M.D.		DATE SIGNED 10 19 57	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 10/11/57	22c. NAME OF CEMETERY OR CREMATORY Memorial Park	22d. LOCATION (City, town, or county) (State) Frostburg Md.
23. FUNERAL DIRECTOR'S SIGNATURE George Eichhorn		ADDRESS Lenaconing, Md.	
24a. REC'D BY REGISTRAR 10-9-57		24b. REGISTRAR'S SIGNATURE Mrs. Nancy H. Rie	

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10

CERTIFICATE OF DEATH

Name of Deceased John Taylor		Sex Male		Age 35	
Date of Death October 10, 1957		Place of Death Home		Cause of Death Heart Disease	
Occupation Teacher		Usual Residence 1234 Main St., Baltimore, Md.		Manner of Death Natural	
Signature of Physician <i>[Signature]</i>		Signature of Coroner <i>[Signature]</i>		Signature of Registrar <i>[Signature]</i>	

BUREAU V. 8

OCT 11 1957

RECEIVED

Name of Registrar George Robinson		Signature of Registrar <i>[Signature]</i>	
Name of Coroner James Smith		Signature of Coroner <i>[Signature]</i>	

CERTIFICATE OF DEATH

Reg. Dist. No.

10143

10129

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westernport				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 43 Westernport			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 323 Maryland Ave.				d. STREET ADDRESS 323 Maryland Ave.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last Robert Thomas Youst, Sr.				4. DATE OF DEATH Month Day Year Oct. 21 1957			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 6, 1902		9. AGE (In years last birthday) 55 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Paper Mill		11. BIRTHPLACE (State or foreign country) W. Va.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Thomas Youst				14. MOTHER'S MAIDEN NAME Rose McDonald			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes		16. SOCIAL SECURITY NO. -1920		17. INFORMANT Address Mrs Robert Youst - Westernport			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 434.2 Congestive heart failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Chronic Asthma DUE TO (c) Emphysema							INTERVAL BETWEEN ONSET AND DEATH years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 002 pulmonary tuberculosis							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April 16, 1957 to October 21, 1957 , that I last saw the deceased alive on October 21, 1957 , and that death occurred at 6:05 A.M. , from the causes and on the date stated above. EST ADDRESS (Street, city or town, state) DATE SIGNED Mildred E. Sheesley M.D. 209 Maryland Ave, Westernport, Md 10-21-57							
ACTUAL SIGNATURE				PHYSICIAN'S NAME (Type) Mildred E. Sheesley, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/23/57		22c. NAME OF CEMETERY OR CREMATORY Augusta Cem.		22d. LOCATION (City, town, or county) (State) Augusta, W. Va.	
23. FUNERAL DIRECTOR'S SIGNATURE E. B. Bual				ADDRESS Westernport, Md.		24a. REC'D BY REGISTRAR DATE 10-23-57	
				24b. REGISTRAR'S SIGNATURE John C Kelly			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, this page should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Manner of Death		Place of Death		Date of Death		Time of Death		Signature of Physician		Signature of Registrar		Signature of Coroner	
Robert Thomas		Male		45		1912		Baltimore, Md.		Baltimore, Md.		Heart Disease		Natural		Baltimore, Md.		October 25, 1957		10:30 AM		[Signature]		[Signature]		[Signature]	
Occupation		Education		Marital Status		Previous Illnesses		Last Medical Examination		Last Hospital Admission		Last Physician's Visit		Last Prescription		Last X-ray		Last Blood Test		Last Urine Test		Last Stool Test		Last Sputum Test		Last Skull X-ray	
Teacher		High School		Married		Hypertension, Diabetes		October 15, 1957		October 15, 1957		October 15, 1957		October 15, 1957		October 15, 1957		October 15, 1957		October 15, 1957		October 15, 1957		October 15, 1957		October 15, 1957	
Date of Death		Time of Death		Place of Death		Cause of Death		Manner of Death		Place of Death		Date of Death		Time of Death		Place of Death		Cause of Death		Manner of Death		Place of Death		Date of Death		Time of Death	
October 25, 1957		10:30 AM		Baltimore, Md.		Heart Disease		Natural		Baltimore, Md.		October 25, 1957		10:30 AM		Baltimore, Md.		Heart Disease		Natural		Baltimore, Md.		October 25, 1957		10:30 AM	

BUREAU V. 3

OCT 25 1957

RECEIVED

DR. DURRETT

10109

CERTIFICATE OF DEATH

Reg. Dist. No.

4

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND	
c. LENGTH OF STAY IN 1b 19 DAYS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL		d. STREET ADDRESS 509 FREDERICK STREET	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First HENRY Middle O. Last ZILCH		4. DATE OF DEATH Month OCTOBER Day 3 Year 19 57	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH AUGUST 9, 1873
9. AGE (In years last birthday) 84 yrs.		10. IF UNDER 1 YEAR Months 8 Days 4 Hours 3 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED - Owner		10b. KIND OF BUSINESS OR INDUSTRY Clothing Store	
11. BIRTHPLACE (State or foreign country) CUMBERLAND, MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME CONRAD ZILCH		14. MOTHER'S MAIDEN NAME JOSEPHINE WIRTHMAN	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, name unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None	
17. INFORMANT MEMORIAL HOSPITAL - CUMBERLAND, MD.		Address	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uræmia 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Chronic Myocarditis DUE TO (c) Arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH 3 wks 4 yrs 10 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 1955 , 1957 , to Dec 3, 1957 , that I lost saw the deceased alive on Oct 3, 1957 , and that death occurred at 11:15 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Cum. Md. DATE SIGNED 10/4/57			
ACTUAL SIGNATURE Clay E. Durrett M.D.		PHYSICIAN'S NAME (Type) DR. CLAY E. DURRETT	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
Burial	10/4/57	St. Lukes Cem.	Cum. Md.
23. FUNERAL DIRECTOR'S SIGNATURE Louis Stein Inc.		24a. REC'D BY REGISTRAR W. Ross Cameron, M.D. 24b. REGISTRAR'S SIGNATURE Acting Registrar	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

OCT 8 1957

BUREAU V. 3

STATE OF MARYLAND
DEPARTMENT OF HEALTH - BALTIMORE 18

CERTIFICATE OF DEATH

NAME OF DECEASED: [illegible]
AGE: [illegible]
SEX: [illegible]
RACE: [illegible]
DATE OF BIRTH: [illegible]
PLACE OF BIRTH: [illegible]
DATE OF DEATH: [illegible]
PLACE OF DEATH: [illegible]
CAUSE OF DEATH: [illegible]
MANNER OF DEATH: [illegible]
SIGNATURE OF PHYSICIAN: [illegible]
SIGNATURE OF REGISTRAR: [illegible]
DATE OF REGISTRATION: [illegible]